

**STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS**

NJ DIRECT

MEMBER HANDBOOK

FOR EMPLOYEES AND RETIREES

ENROLLED IN THE

**STATE HEALTH BENEFITS PROGRAM OR
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

PLAN YEAR 2013

**ADMINISTERED FOR THE DIVISION OF PENSIONS AND BENEFITS BY
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY**

TABLE OF CONTENTS

INTRODUCTION	1
NJ DIRECT	2
HEALTH BENEFITS PROGRAM ELIGIBILITY	3
ACTIVE EMPLOYEE ELIGIBILITY	3
STATE EMPLOYEES	3
LOCAL EMPLOYEES	3
ENROLLMENT	4
ELIGIBLE DEPENDENTS	4
SUPPORTING DOCUMENTATION REQUIRED FOR ENROLLMENT OF DEPENDENTS	6
AUDIT OF DEPENDENT COVERAGE	6
MULTIPLE COVERAGE UNDER THE SHBP/SEHBP IS PROHIBITED	6
MEDICARE COVERAGE WHILE EMPLOYED	6
RETIREE ELIGIBILITY	7
Aggregate of Pension Membership Service Credit	8
Eligible Dependents of Retirees	9
Multiple Coverage under the SHBP/SEHBP is Prohibited	9
Enrolling in Retired Group Coverage	9
MEDICARE COVERAGE	9
Medicare Parts A and B	9
Medicare Part D	10
Medicare Eligibility	10
How to File a Claim If You Are Eligible for Medicare	12
GENERAL CONDITIONS OF THE PLAN	13
Medical Need and Appropriate Level of Care	13
Health Care Fraud	13
PRECERTIFICATION OF BENEFITS IN-NETWORK AND OUT-OF-NETWORK	14
NJ DIRECT SERVICES REQUIRING PRECERTIFICATION	14
Predetermination of Benefits	17
UTILIZATION MANAGEMENT	17
Reasonable and Customary Allowances	17
Experimental or Investigational Treatments	18

NJ DIRECT PLAN BENEFITS	19
IN-NETWORK BENEFITS	19
Copayments	19
Coinsurance (In-Network)	19
OUT-OF-NETWORK BENEFITS	20
Deductible	20
NJ DIRECT Deductible Amounts	20
Coinsurance (Out-of-Network)	21
NJ DIRECT HIGH DEDUCTIBLE HEALTH PLAN BENEFITS	22
DEDUCTIBLES	22
In-Network and Out-of-Network Deductibles (Combined)	22
IN-NETWORK BENEFITS	22
OUT-OF-NETWORK BENEFITS	23
OUT-OF-POCKET MAXIMUMS	23
HORIZON <i>MyWay</i> HSA	24
Horizon <i>MyWay</i> Welcome Materials	25
COORDINATION OF BENEFITS	26
GENERAL BENEFITS	27
Acupuncture	27
Alcoholism and Substance Abuse Treatment	27
Allergy Testing and Treatment	28
Ambulance	28
Audiology Services	28
Autism or Another Developmental Disability	28
Automobile-Related Injuries	29
Biofeedback	29
Birthing Centers	29
Blood	30
Breast Reconstruction	30
Chiropractic Services	30
Congenital Defects	30
Dental Care	30
Diabetic Self-Management Education	31
Dialysis	32

Durable Medical Equipment and Supplies	32
Emergency Medical Services	32
Emergency Room	33
Federal Government Hospitals	33
Gynecological Care and Examinations	33
Hearing Aids	33
Hemophilia Treatment	34
Home Health Care	34
Hospice Care Benefits	34
Immunizations	35
Infertility Treatment	36
Lead Poisoning Screening and Treatment	37
Lithotripsy Centers	37
Lyme Disease Intravenous Antibiotic Therapy	37
Mammography	38
Mastectomy Benefits	38
Maternity/Obstetrical Care	38
Maternity/Obstetrical Care for Child Dependents	38
Mental or Nervous Conditions	38
Nutritional Counseling (In-Network Only)	39
Occupational Therapy	39
Organ Transplant Benefits	39
Pain Management	39
Pap Smears	40
Patient Controlled Analgesia (PCA)	40
Physical Therapy/Occupational Therapy	40
Physicals (In-Network Only)	40
Pre-Admission Hospital Review (In-Network and Out-of-Network)	41
Pre-Admission Testing Charges	41
Prostate Cancer Screening (In-Network Only)	41
Scalp Hair Protheses	41
Second Surgical Opinion	41
Shock Therapy Benefits	42
Skilled Nursing Facility Charges	42
Speech Therapy Benefit	42

Surgical Services (Out-of-Network)	42
Temporomandibular Joint Disorder (TMJ) and Mouth Conditions	43
Vision Care Benefits	43
CHARGES NOT COVERED BY NJ DIRECT	43
THIRD PARTY LIABILITY	50
Repayment Agreement	50
Recovery Right	50
SUBROGATION AND REIMBURSEMENT	50
WHEN YOU HAVE A CLAIM	51
Submitting a Claim (In-Network)	51
Submitting a Claim (Out-of-Network)	51
Filing Deadline (Proof of Loss)	52
Itemized Bills are Necessary	52
Foreign Claims	52
Filling Out the Claim Form	52
MEDICARE CLAIM SUBMISSION	53
AUTHORIZATION TO PAY PROVIDER	53
QUESTIONS ABOUT CLAIMS	53
APPEAL PROCEDURES	54
NJ DIRECT MEDICAL APPEAL PROCEDURE	54
First Level Medical Appeal	54
Expedited Review	55
Second Level Medical Appeals	55
Expedited Review of Second Level Medical Appeals	56
EXTERNAL APPEAL RIGHTS	56
Standard External Appeals	56
NJ DIRECT ADMINISTRATIVE APPEAL PROCEDURE	58
First Level Administrative Appeal	58
Second Level Administrative Appeal	59
Commission Appeal	59
PRESCRIPTION DRUG BENEFITS	61
EMPLOYEE PRESCRIPTION DRUG COVERAGE	61
State Employees	61
Prescription Drug Plan Copayments State Employees	62

Local Government and Local Education Employees	62
Prescription Drug Plan Copayments	
Local Government and Local Education Employees	63
NJ DIRECT Prescription Drug Plan Coinsurance	
Local Government and Local Education Employees.....	64
RETIREE PRESCRIPTION DRUG COVERAGE	65
Medicare Part D	65
RETIREE PRESCRIPTION DRUG COPAYMENTS	65
State Retirees and Local Government Retirees	65
Local Education Retirees	66
COBRA COVERAGE	67
CONTINUING COVERAGE WHEN IT WOULD NORMALLY END	67
COBRA Events	67
Cost of COBRA Coverage	68
Duration of COBRA Coverage	68
Employer Responsibilities Under COBRA	68
Employee Responsibilities Under COBRA	69
Failure to Elect COBRA Coverage	69
Termination of COBRA Coverage	70
APPENDIX I	71
SPECIAL PLAN PROVISIONS UNDER NJ DIRECT	71
WORK-RELATED INJURY OR DISEASE	71
MEDICAL PLAN EXTENSION OF BENEFITS	71
TERMINATION FOR CAUSE	72
APPENDIX II	73
SUMMARY SCHEDULE OF SERVICES AND SUPPLIES	73
NJ DIRECT ELIGIBLE SERVICES AND SUPPLIES	73
NJ DIRECT COVERED SERVICES	74
NJ DIRECT HDHP ELIGIBLE SERVICES AND SUPPLIES	79
NJ DIRECT HDHP COVERED SERVICES	79
APPENDIX III	85
GLOSSARY	85

APPENDIX IV	95
REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT	95
APPENDIX V	97
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	97
Certification of Coverage	97
HIPAA Privacy	97
APPENDIX VI	98
NOTICE OF PRIVACY PRACTICES	98
Protected Health Information	98
Uses and Disclosures of PHI	98
Restricted Uses	99
Member Rights	99
Questions and Complaints	101
APPENDIX VII	102
HEALTH BENEFITS PROGRAM CONTACT INFORMATION	102
Addresses	102
Telephone Numbers	102
HEALTH BENEFITS PROGRAM PUBLICATIONS	104
General Publications	104
Member Handbooks	104

An online version of this handbook containing current updates is available for viewing at: www.state.nj.us/treasury/pensions/health-benefits.shtml Be sure to check the Division of Pensions and Benefits Internet home page at: www.state.nj.us/treasury/pensions for forms, fact sheets, and news of any new developments affecting your health benefits.

INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents; and dental coverage to qualified State and local government/education public employees, retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP. The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Chairman of the Civil Service Commission, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a local employee representative chosen by the Public Employees' Committee of the AFL-CIO. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP. The SEHBC includes the State Treasurer, the Commissioner of the Department of Banking and Insurance, an appointee of the Governor, an appointee from New Jersey School Board Association, three appointees from New Jersey Education Association, an appointee from New Jersey State AFL-CIO, and a chairperson appointed by the Governor from nominations submitted by the other members of the commission. The Director of the Division of Pensions and Benefits is the Secretary to the SEHBC.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP and the SEHBP.

Every effort has been made to ensure the accuracy of the *NJ DIRECT Member Handbook*; which describes the benefits provided in the contract with Horizon BCBSNJ. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, the law, regulations, and contracts will govern. **Furthermore, if you are unsure whether a procedure is covered, contact your plan before you receive services to avoid any denial of coverage issues that could result.**

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send an e-mail to: pensions.nj@treas.state.nj.us

NJ DIRECT

Except where identified, the NJ DIRECT benefits described in this member handbook are identical for SHBP and SEHBP members.

NJ DIRECT is administered for the Division of Pensions and Benefits by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ).

NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, and NJ DIRECT2030 provide both **in-network** and **out-of-network** benefits.

- **In-network** care is provided through a network of providers which includes internists, general practitioners, pediatricians, specialists, and hospitals. Network providers offer a full range of services that include well-care and preventive services such as annual physicals, well-baby/well-child care, immunizations, mammograms, annual gynecological examinations, and prostate examinations. In-network services are generally covered in full after a member copayment. Most in-network hospital admissions are covered in full. For in-patient mental health hospitalization information see page 76.
- **Out-of-network** benefits provide reimbursement for expenses for eligible services rendered for the treatment of illness and injury. Most out-of-network care is usually reimbursed at a percentage of the reasonable and customary allowance after an annual member deductible is met, see page 17. Under the SHBP, out-of-network inpatient hospital admissions are subject to a separate \$200 deductible per admission.

NJ DIRECT HD1500 and NJ DIRECT HD4000 combine a **High Deductible Health Plan (HDHP)** with a **Health Savings Account (HSA)** and may be referred to as a **Consumer Driven Health Plan**.

- High Deductible Health Plans contain a high annual deductible and members are responsible for eligible medical expenses up to the deductible. NJ DIRECT HDHP provides both in-network and out-of-network benefits. Eligible preventive services are covered at 100 percent and are not subject to the deductible. Both medical and prescription drug coverage is included. After the annual deductible is met the member is responsible for 20 percent of the plan allowance for in-network services and 40 percent of the reasonable and customary allowance, along with any amounts in excess of the allowance, for out-of-network services. If eligible expenses reach the out-of-pocket maximum, eligible services will be covered at 100 percent of the allowance, subject to all plan provisions. For more information see page 23.
- Horizon *MyWay* HSA is available to all NJ DIRECT HDHP subscribers. HSAs are a type of personal savings account funded by the subscriber, employer (NJ DIRECT HD1500 only) or both. Horizon *MyWay* HSA funds may be used to pay for **qualified medical expenses** including prescription drugs, as outlined by the IRS. For more information see page 25.

NJ DIRECT is self funded. Funds for the payment of claims and services come from funds supplied by the State, participating local employers, and members.

Refer to page 102 for additional information on contacting NJ DIRECT, the Division of Pensions and Benefits, and related health services.

HEALTH BENEFITS PROGRAM ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Division of Pensions and Benefits. If you have any questions concerning eligibility provisions, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524. Or send e-mail to: pensions.nj@treas.state.nj.us

STATE EMPLOYEES

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires at least 35 hours per week or more if required by contract or resolution.

The following State employees are also eligible for coverage in NJ DIRECT.

State Part-Time Employees — Part-time employees of the State and part-time faculty at institutions of higher education that participate in the SHBP are eligible for coverage if they are members of a State-administered pension system. The employee or faculty member must pay the full cost of the coverage. Part-time employees will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in retired group coverage at their own expense provided they were covered up to the date of retirement. See [Fact Sheet #66](#), *Health Benefits Coverage for Part-Time Employees*, for more information.

The following State employees are eligible for coverage in **NJ DIRECT15**.

State Intermittent Employees — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) are eligible for coverage. Intermittent employees who maintain 750 hours of work per year continue to qualify for coverage in subsequent years. See [Fact Sheet #69](#), *SHBP Coverage for State Intermittent Employees*, for more information.

New Jersey National Guard — A member of the New Jersey National Guard who is called to State active duty for 30 days or more is eligible to enroll in at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and the Division of Pensions and Benefits of members who are eligible for coverage.

LOCAL EMPLOYEES

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP or SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. Employment must also be for

12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

The following local employees are also eligible for coverage in NJ DIRECT.

Local Part-Time Employees — A part-time faculty member employed by a county or community college that participates in the SEHBP is eligible for coverage if they are members of a State-administered pension system. The faculty member must pay the full cost of the coverage. Part-time faculty members will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in retired group coverage at their own expense provided they were covered up to the date of retirement. See [Fact Sheet #66, Health Benefits Coverage for Part-Time Employees](#), for more information.

ENROLLMENT

You are not covered until you enroll in the SHBP or SEHBP. You must fill out a [Health Benefits Program Application](#) and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the Division of Pensions and Benefits.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse, civil union partner or eligible same-sex domestic partner, and your eligible children (as defined below).

Spouse — A person of the opposite sex to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or [Fact Sheet #75, Civil Unions](#), for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or [Fact Sheet #71, Benefits Under the Domestic Partnership Act](#), for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (PPACA), coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment (non-custodial parents, see page 96).

For a stepchild provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent **and** a photocopy of marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate **and** additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee (see page 96).

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section on page 67, "Dependent Children with Disabilities" and "Over Age Children Until Age 31" below for continuation of coverage provisions).

Dependent Children with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance and lives with you. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Over Age Children Until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of non-payment.

See [Fact Sheet #74](#), *Health Benefits Coverage of Children until Age 31 under Chapter 375*, for details.

SUPPORTING DOCUMENTATION REQUIRED FOR ENROLLMENT OF DEPENDENT

The SHBP and SEHBP are required to ensure that only eligible employees and retirees, and their dependents, are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 95 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

AUDIT OF DEPENDENT COVERAGE

Periodically, the Division of Pensions and Benefits performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

MULTIPLE COVERAGE UNDER THE SHBP/SEHBP IS PROHIBITED

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union or domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD), and the 30-month coordination of benefits period has ended, you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work. For more information, see “Medicare Coverage” beginning on page 9 in the “Retiree Eligibility” section.

RETIREE ELIGIBILITY

The following individuals will be offered SHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement and begin receiving a monthly retirement benefit or lifetime annuity immediately following termination of employment.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment.
- Certain local policemen or firemen with 25 years or more of service credit in the retirement system or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See [Fact Sheet #47](#), *Retired Health Benefits Coverage under Chapter 330*, for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

The following individuals will be offered SEHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with 25 years or more of service credit in one or more State or locally-administered retirement systems or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit" on page 8).
- Full-time members of the TPAF or PERS who retire from a board of education, vocational/ technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B. A qualified retiree may enroll at retirement or when he or she becomes eligible for Medicare.
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire with at least 25 years of credited ABP service or those who are on a long-

term disability and begin receiving a monthly lifetime annuity immediately following termination of employment.

- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

Eligibility for SHBP or SEHBP membership for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is enrolled in the SHBP or SEHBP immediately preceding the effective date of your retirement.

This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment; you will lose your eligibility for Retired Group health coverage. (This does not include former full-time employees enrolled in TPAF and PERS board of education or county college who retire with 25 or more years of service).

Note: If you continue group coverage through COBRA (see the “COBRA” section on page 67) — or as a dependent under other coverage through a public employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.

Otherwise qualified employees whose coverage is terminated prior to retirement **but who are later approved for a *disability retirement*** will be eligible for Retired Group coverage beginning on the employee’s retirement date. If the approval of the disability retirement is delayed, coverage shall not be retroactive for more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP or SEHBP; subject to the applicable retiree contribution, if any.

A full-time employee of a local government who has 25 years or more of service credit whose employer participates in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP.

A retiree eligible for the SHBP or SEHBP may receive this benefit if the 25 years of service credit is from one or more State or locally-administered retirement systems and the time credited is nonconcurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency, requested for purchase after November 1, 2008, cannot be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Chapter 334 domestic partners (described below) and the Medicare requirements (see below).

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement (see page 7), may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Enrolling in Retired Group Coverage

The Health Benefits Bureau is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

If you do not submit a [*Retired Coverage Enrollment Application*](#) at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See [*Fact Sheet #11, Enrolling for Health Benefits Coverage When You Retire*](#), for more information.

If you believe you are eligible for Retired Group coverage and do not receive an offering letter by the date of your retirement, please contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or send an e-mail to: [*pensions.nj@treas.state.nj.us*](mailto:pensions.nj@treas.state.nj.us)

Additional restrictions and/or requirements may apply when enrolling for Retired Group coverage. Be sure to carefully read the "Retiree Enrollment" section of the [*Summary Program Description*](#).

MEDICARE COVERAGE

Medicare Parts A and B

IMPORTANT: A Retired Group member and/or dependent spouse, civil union partner, eligible same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP or SEHBP Retired Group coverage.

You will be required to submit documented evidence of enrollment in Medicare Part A and Part B when you or your dependent becomes eligible for that coverage. Acceptable

documentation includes a photocopy of the Medicare card showing both Part A and Part B enrollment, or a letter from Medicare indicating the effective dates of both Part A and Part B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 341-3407. If you do not submit evidence of Medicare coverage under both Part A and Part B, you and/or your dependents will be terminated from coverage. Upon submission of proof of full Medicare coverage, your Retired Group coverage will be reinstated by the Health Benefits Bureau on a prospective basis.

IMPORTANT: When coordinating benefits with Medicare, the secondary benefit under NJ DIRECT is supplemental to the Medicare payment. NJ DIRECT will consider the remaining Medicare coinsurance and deductible as the allowable expense and apply the applicable copayments, coinsurance, or deductible when appropriate. If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP or SEHBP for the provider's services, the charges would not be considered under the medical plan, and the member will be responsible for the charges.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in Medicare Part D and the Express Scripts Medicare Prescription Drug Plan.

Important: If you decide not to be enrolled in the Express Scripts Medicare Prescription Drug Plan, you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Express Scripts Medicare Prescription Drug Plan, you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a [Retired Change of Status Application](#) waiving your prescription drug coverage.

Medicare Eligibility

In most cases a Retired Group member and/or dependent should enroll in Medicare Part A and Part B coverage as soon as they become eligible. Otherwise, an individual can only enroll during Medicare's annual "General Enrollment Period" (January 1 through March 31) and late enrollment penalties *may* apply (visit www.medicare.gov or contact Medicare at 1-800-633-4227 for more information).

A member may be eligible for Medicare for the following reasons:

- ***Medicare Eligibility by Reason of Turning Age 65***

A member (the retiree or covered spouse/partner) is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The retired group health plan is the secondary plan.

- ***Medicare Eligibility by Reason of Disability***

A member (the retiree or covered spouse/partner or dependent) who is under age 65 is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The retired group health plan is the secondary plan.

- ***Medicare Eligibility by Reasons of End Stage Renal Disease***

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member (the retiree or covered spouse/partner or dependent) who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- ✓ The individual has group health coverage of their own or through a family member (including a spouse/partner).
- ✓ The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules listed above, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, **the group health plan is primary.**

Coordination of benefits period

During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage.** Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD, the coordination of benefits period is 30 months.

When Medicare is primary

After the coordination of benefits period ends, **Medicare is considered the primary payer and the group health plan is secondary.** If you are eligible for Medicare by reason of ESRD and Medicare is primary, you must enroll in Medicare A and B and submit proof of enrollment to the SHBP/SEHBP. If you do not enroll in Medicare A and B before the end of the coordination of benefits period, your SHBP/SEHBP coverage will be terminated. It is your responsibility to ensure that you file your application for Medicare so that the Medicare effective date is on or before the date that the coordination of benefits period ends.

Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- ✓ If the health plan is primary because the member has active employment status, then **the group health plan continues to be primary** for 30 months from the date of dual Medicare entitlement.

- ✓ If the health plan is secondary because the member is not actively employed, then **the health plan continues to be the secondary payer**. There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number should be written on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."
- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to the Plan for their consideration in processing supplementary coverage benefits."
- If the statement shown above does not appear on the *Explanation of Benefits*, you should indicate your NJ DIRECT identification number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed NJ DIRECT claim form and send it to the address on the claim form.

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Retirees Enrolled in Medicare Who Move Outside the United States

Members who reside outside the United States must still maintain their Medicare coverage (Part A and Part B) in order to be covered under Retired Group coverage; however, Medicare does not cover services outside the United States. For members who reside outside the United States, NJ DIRECT covers services as if NJ DIRECT were primary.

Members, who reside outside the United States, even if they reside in a country with a national health plan, should consider that if they travel outside their country of residence they will still need coverage. In order to have coverage at any time in the future, the member must stay enrolled in the SHBP or SEHBP, since once a member terminates coverage they will not be reinstated.

GENERAL CONDITIONS OF THE PLAN

All benefits listed in this handbook may be subject to limitations and exclusions as described in subsequent sections. All pertinent parts of this handbook should be consulted regarding a specific benefit.

Even though a service or supply may not be described or listed in this handbook, that does not mean the service or supply is eligible for benefits under NJ DIRECT.

NJ DIRECT will pay only for eligible services or supplies that meet the following conditions:

- Are medically needed at the appropriate level of care (see below) for the medical condition. (When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by Horizon BCBSNJ.)
- Are listed in the “Eligible Services and Supplies” section on page 73.
- Are ordered by an eligible provider for treatment of illness or injury.
- Were provided while you or your eligible covered dependents were covered by NJ DIRECT.
- Are not specifically excluded (listed in the “Charges Not Covered by NJ DIRECT” section on page 43).

When you use an out-of-network provider, all services, supplies, tests, etc. prescribed by the out-of-network provider, including hospitalization, are reimbursed at a percentage of the reasonable and customary allowance after deductibles and coinsurance have been met. The member is responsible for any amount charged by the physician that is above and beyond the reasonable and customary allowance in addition to deductibles and coinsurance.

Medical Need and Appropriate Level of Care

The medical need and appropriate level of care for any service or supply is determined by Horizon BCBSNJ and must meet **each** of these requirements:

- It is ordered by an eligible provider for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use.
- That it is the most appropriate level of service or supply considering the potential benefits and possible harm to the patient.

See also “Experimental or Investigational Treatments” on page 18.

Health Care Fraud

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

PRECERTIFICATION OF BENEFITS IN-NETWORK AND OUT-OF-NETWORK

A precertification is required for certain services and all inpatient admissions. Failure to obtain a precertification may result in benefits being denied. Participating physicians and hospitals will obtain precertification on your behalf. Horizon BCBSNJ will conduct a review of any services that were not precertified to determine eligibility. If you do not obtain precertification, payment may not be made for services that are determined to be not medically appropriate.

NJ DIRECT SERVICES REQUIRING PRECERTIFICATION

Accidental Dental Injuries

Air Ambulance

Alcohol and Substance Abuse Specialty Services, including:

- All Alcohol and substance abuse confinements including residential and partial hospitalization admissions.
- Intensive Outpatient (IOP) Treatment
- Office Based Opioid Treatment (OBOT)

Applied Behavioral Analysis (ABA)

Cancer Clinical Trials

Durable Medical Equipment (DME) (see examples below)

- Electric, customized or motorized wheelchairs and scooters, and powered accessories
- Electric beds/Clinitron/power hospital beds/air mattresses/power accessories
- Enteral formula
- Bone stimulators
- Neurostimulators
- Lymphadema pumps
- External defibrillators
- All rentals

Inpatient Admissions

- All acute care confinements, exclusive of maternities, including:
 - ✓ Surgical admissions
 - ✓ Medical admissions
 - ✓ Hospice admission
 - ✓ All Skilled Nursing Facility (SNF) confinements
- All Rehabilitation Facility confinements
- All Sub-Acute confinements

- Mental health and substance abuse confinements (including Residential, Partial Hospitalizations, and Intensive Out-Patient Admissions.)

Home Health Care Services

Home Hospice Services

Hyperbaric Oxygen Therapy

Infertility Services

- Gamete intrafallopian transfer
- In vitro fertilization
- Zygote intrafallopian transfer
- Artificial insemination
- Hysterosalpingography

Home Infusion (IV) Therapy

Lyme Disease Intravenous Antibiotic Therapy

Mental Health (Biologically Based and Non-Biologically Based) Specialty Services, including:

- All Mental health Confinements (including Residential, Partial Hospitalizations, and Intensive Out-Patient Admissions.)
- Psychological Testing
- Outpatient Electroconvulsive therapy (ECT)
- Biofeedback

Specific Medications administered in a physician's office or dialysis facility (review performed by Care Core National)

- Aranesp
- Epogen
- Procrit

Pain Management (see page 39 for additional details)

Private Duty Nursing in the Home (Inpatient PDN is ineligible)

Radiology (review services performed by Care Core National)

- CT/CTA Scans
- MRI/MRA
- Nuclear Medicine/Nuclear Cardiology
- PET and PET/CT Scans
- Echo Stress Tests
- Diagnostic Left Heart Catheterization

Reconstructive Procedures that may be considered Cosmetic:

- Blepharoplasty/Canthopexy/Canthoplasty
- Excision of excessive skin due to weight loss
- Rhinoplasty/rhytidectomy
- Pectus excavatum repair
- Breast reconstruction/enlargement
- Breast reduction/mammoplasty
- Lipectomy or excess fat removal
- Sclerotherapy or surgery for varicose veins
- Facial reconstruction or repair including:
 - ✓ Orthognathic surgery
 - ✓ Bone grafts
 - ✓ Osteotomies
 - ✓ Surgical management of temporomandibular joint
- Any other potentially cosmetic procedure

Specialty Pharmaceuticals**Spinal Disk Surgeries** (including but not limited to):

- Percutaneous Laser Discectomy
- Nucleoplasty
- Spinal Fusion

Surgery for Morbid Obesity (including but not limited to):

- Gastroplasty
- Gastric Bypass
- Bariatric Procedures

Therapy Services:

- Cognitive Therapy
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Transplants

- Lung
- Liver
- Heart
- Pancreas

- Autologous Bone Marrow
- Cornea
- Kidney
- Autologous Chondrocyte Transplants
- Uvulopalatopharyngoplasty (UPPP)

Predetermination of Benefits

A predetermination for any service may be obtained ***in writing*** in advance of services being rendered. The written request will need to include the provider's name, address, and phone number, the diagnosis, a description of the services to be rendered, and the anticipated charges. Telephone contact with Horizon BCBSNJ or the Division of Pensions and Benefits about coverage does not constitute a predetermination of benefits. If the actual services rendered differ from those described in the written request, the predetermination of benefits will have no effect. A predetermination is valid for one year from the date issued. All requests for written predeterminations must include all necessary medical documentation and must be presented to Horizon BCBSNJ three to four weeks prior to the services being rendered. If Horizon BCBSNJ requires additional medical information, the written response may be delayed.

UTILIZATION MANAGEMENT (Medical Management and Review)

Both in-network and out-of-network treatment is subject to Utilization Management (UM), a process used to ensure that treatment is medically needed and provided at the appropriate level of care. When the treatment is proposed by an in-network provider, the provider is responsible for the UM contact. Benefits are payable for in-network treatment when they are provided by an in-network provider, the UM organization has been notified to review the treatment, and the UM organization has approved the treatment.

Out-of-network benefits that are actually payable will also depend on whether the patient or patient's provider has or has not contacted the UM organization in regard to proposed medical treatment and whether the UM organization agrees that the treatment is needed and at the appropriate level of care. If the member is utilizing a non-participating physician, they should request their non-participating physician to contact Utilization Management at the number listed on their ID card (1-800-664-2583). If a member calls this number to request precertification, the UM organization's Precertification Department will request the phone number of the physician and will contact the physician to obtain the clinical information needed in order to review the services requested.

For out-of-network benefits when the patient has failed to contact the UM organization at Horizon BCBSNJ, treatment will be considered not certified and expenses will not be applied to the annual out-of-pocket maximum. However, if the treatment is eligible, reimbursement will be made at the appropriate percentage of reasonable and customary allowances after any deductible has been met.

Reasonable and Customary Allowances (for Out-of-Network Services)

NJ DIRECT covers only reasonable and customary allowances, which are determined by the FAIR Health benchmark charge data or a similar nationally recognized database. This

schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.

In some instances the out-of-network allowance is derived from an alternate nationally recognized source. One example is Ambulatory Surgery Centers (ASC's). The out-of-network plan allowance used for ASC's is based on a percentage of the Centers for Medicare and Medicaid Services (CMS) allowance.

Experimental or Investigational Treatments

NJ DIRECT **does not** cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. For the purpose of this exclusion, a service or supply will be considered experimental or investigational if Horizon BCBSNJ determines that one or more of the following is true.

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II, and III clinical trials, with the exception of approved cancer trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other research settings. Horizon BCBSNJ will determine this based on:
 - Published reports in authoritative medical literature; and
 - Regulations, reports, publications, and evaluations issued by US government agencies such as the Agency for Health Care Research and Quality, the National Institutes of Health, and the federal Food and Drug Administration (FDA).
3. The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
4. The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such consent.
5. Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.
6. The service or supply is not recognized by the prevailing opinion within the appropriate medical specialty as an effective treatment for the particular diagnosis or set of indications.
7. Additionally, if it is a drug, device, or other supply that is subject to FDA approval it will be considered experimental and investigational if it:
 - Does not have FDA approval for sale and use in the United States (that is, for introduction into and distribution in interstate commerce); or
 - Has FDA approval only under the Treatment Investigational New Drug regulation or a similar regulation; or
 - Has FDA approval, but is being used for an indication or at a dosage that is not an acceptable off-label use. Horizon BCBSNJ will determine if a certain use is an

accepted off-label use based on published reports in peer-reviewed, authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Dispensing Information.

NJ DIRECT PLAN BENEFITS

Unless otherwise indicated, this section refers to NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, and NJ DIRECT 2030.

IN-NETWORK BENEFITS

You can benefit most from NJ DIRECT when you obtain your care from in-network providers. When you are treated in-network, you are covered for treatment of illness or injury in addition to well-care and preventive services. NJ DIRECT will pay, in most cases, the full cost after an appropriate member copayment per visit.

Copayments

Copayments apply to in-network services unless otherwise indicated.

- **NJ DIRECT10** has a \$10 copayment.
- **NJ DIRECT15** has a \$15 copayment.
- **NJ DIRECT1525** has a \$15 copayment for primary care physician visits and a \$25 copayment for specialist visits.
- **NJ DIRECT2030** has a \$20 copayment for primary care physician visits or specialist visits for children up to the end of the year the child turns 26 and a \$30 copayment for adult specialist visits.

In-network care is provided through a network of providers that includes internists, general practitioners, specialists, pediatricians, and hospitals. No referrals are needed for visits to a specialist. If the physician participates in the Horizon BCBSNJ Managed Care Network, the member only pays the appropriate copayment. Members living or accessing services outside of New Jersey can utilize physicians participating in the national BlueCard® PPO Network.

In-network hospital admissions are also covered in full in most cases. If the physician does not participate in the Horizon BCBSNJ Managed Care Network or the national network, the services will be considered out-of-network. Contact your doctor to see if he or she participates in the Horizon BCBSNJ Managed Care or national network.

To find current participating physicians in New Jersey contact Horizon BCBSNJ directly at 1-800-414-SHBP or visit: www.horizonblue.com/shbp

Coinsurance (In-Network)

Select in-network services require the member to pay coinsurance instead of a copayment. Examples of the types of service requiring the coinsurance are durable medical equipment and ambulance services. Once the member reaches the in-network out-of-pocket maximum of \$400 under NJ DIRECT10, NJ DIRECT15 and NJ DIRECT1525, or the in-network out-of-

pocket maximum of \$800 under the NJ DIRECT2030, NJ DIRECT will pay 100 percent of the cost of these types of covered services.

OUT-OF-NETWORK BENEFITS

NJ DIRECT includes an option for using out-of-network providers. When you exercise this out-of-network option, you will be responsible for deductibles and a percentage of coinsurance based on a reasonable and customary fee schedule, and any amount exceeding the reasonable and customary allowances for all services. NJ DIRECT's out-of-network benefits do not cover most well-care or preventive care.

The out-of-network determination is based on the participating status of the provider such as the physician, specialist, therapist, hospital/facility rendering the service. For example, if you utilize a non-participating doctor and services are provided at an in-network hospital, the doctor will be paid at the out-of-network level and the hospital will be paid at the in-network level.

If you do not contact NJ DIRECT for prior certification for selected services (see page 14) your claims may be paid at the out-of-network level of benefits, if the services are deemed to be medically appropriate, and the amount that you are required to pay will not apply to the out-of-network maximums.

Deductible

NJ DIRECT annual deductible for out-of-network benefits that the individual or family must meet before an out-of-network charge is paid differs depending on the NJ DIRECT coverage you select. NJ DIRECT10, NJ DIRECT15, and NJ DIRECT 1525 include an annual out-of-network deductible of \$100 per individual and \$250 per family. NJ DIRECT2030 includes an annual out-of-network deductible of \$200 per individual and \$500 per family.

NJ DIRECT Deductible Amounts

LEVEL OF COVERAGE	NJ DIRECT10 NJ DIRECT15 NJ DIRECT1525	NJ DIRECT2030
Single	\$100	\$200
Member and Spouse/Partner	\$100 per person	\$200 per person
Family or Parent and Child(ren)	\$250 in aggregate for all family members, but no more than \$100 per person	\$500 in aggregate for all family members, but no more than \$200 per person

For SHBP NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525 members, an out-of-network inpatient hospital admission has a separate \$200 deductible per admission; \$500 per admission for **SHBP NJ DIRECT2030 members.**

For SEHBP NJ DIRECT1525 members, an out-of-network inpatient hospital admission has a separate \$200 deductible per admission; \$500 per admission for **SEHBP NJ DIRECT2030 members.**

The benefit year in which the deductible is measured runs from January 1 to December 31. However, if treatment for an illness or injury is provided during the last three months of the year, the allowable expenses that were applied toward the deductible may be allowed to "carry over" toward meeting the deductible for the following year.

Deductible Examples:

Single Coverage — You incur an out-of-network doctor's office visit in April 2013 and the allowable expense is \$100. This is your first claim of the year and no other calendar year deductible has been met; therefore the \$100 allowable expense is applied to and satisfies the deductible for 2013.

Family Coverage/Aggregate — You and two covered family members incur an out-of-network doctor's office visit in May 2013. The allowable expense is \$85 per visit or \$255 for all three visits. These are your family's first claims of the year and no other calendar year deductible has been met; therefore \$85 for the first two visits is applied toward the family deductible (\$170) along with \$80 from the third visit (\$250). The \$250 family deductible is met for 2013.

Family Coverage/Individual — You or a family member incur an out-of-network doctor's office visit in May 2013 and the allowable expense is \$100. This is the first claim of the year and no other calendar year deductible has been met, therefore the \$100 allowable expense is applied to and satisfies the individual deductible for 2013. The \$100 allowable expense is also applied toward the \$250 family deductible for 2013.

Deductible Carryover — You incur an out-of-network doctor's office visit in October 2013 and the allowable expense is \$90. This is your first claim of the year and no other calendar year deductible has been met; therefore the full \$90 allowable expense is applied to the deductible for 2013. Since this amount was applied in the last three months of 2013, the full \$90 will carry over and be applied toward meeting the 2014 deductible as well if you remain in the same plan.

Coinsurance (Out-of-Network)

NJ DIRECT will pay a percentage of the reasonable and customary allowance for eligible out-of-network charges. You are required to pay the remaining percentage of the reasonable and customary allowance as well as the difference between the allowance and the provider's charges. When your out-of-pocket amount for the year totals \$2,000 per individual or \$5,000 per family under NJ DIRECT10, NJ DIRECT15 and NJ DIRECT1525 or \$5,000 individual and \$12,500 family under NJ DIRECT2030, the plan will pay 100 percent of the reasonable and customary allowance for eligible services.

When your out-of-pocket amount for the year totals \$2,000 per individual or \$5,000 per family under NJ DIRECT10, NJ DIRECT15 or NJ DIRECT1525, the plan will pay 100 percent of the reasonable and customary allowance for eligible services. Under NJ DIRECT2030, the plan will pay 100 percent of the reasonable and customary allowance for eligible services when your out-of-pocket amount for the year totals \$5,000 per individual or \$12,500 per family.

For SEHBP members, in-network out-of-pocket expenses apply to the out-of-network out-of-pocket maximum under NJ DIRECT10. Only coinsurance goes toward the in-network out-of-pocket expenses under NJ DIRECT15, NJ DIRECT1525, and NJ DIRECT2030.

The member is responsible for any amount above the reasonable and customary allowance in addition to deductible and coinsurance liability. Eligible services and precertified treatment count toward the NJ DIRECT maximum out-of-pocket expense level. Expenses for ineligible services and charges in excess of reasonable and customary allowances do not count toward your out-of-pocket maximums and are your financial responsibility.

NJ DIRECT HIGH DEDUCTIBLE HEALTH PLAN BENEFITS

Unless otherwise indicated, this section refers to NJ DIRECT HD1500 or NJ DIRECT HD4000.

DEDUCTIBLES

NJ DIRECT HDHP members have one annual deductible that is combined for in-network and out-of-network medical and prescription drug products and services. The entire deductible must be met before any eligible charges are reimbursed. The annual deductible applies to all services unless otherwise indicated. No copayments apply.

For reference, the NJ DIRECT HDHP annual deductibles are listed below:

In-Network and Out-of-Network Deductibles (Combined)

NJ DIRECT HD1500:	\$1,500 Single
	\$3,000 Member & Spouse/Partner, Parent & Child(ren) or Family
NJ DIRECT HD4000:	\$4,000 Single
	\$8,000 Member & Spouse/Partner, Parent & Child(ren) or Family

The benefit year in which the deductible is measured runs from January 1 to December 31. Covered services incurred during the benefit year will be applied to the annual deductible. No carryover applies.

Certain services require authorization to receive full benefits and to have those expenses applied toward the annual deductible. For a list of services requiring precertification, please refer to page 14. You should get those services preauthorized even if your deductible has not been met and you wish to use your HSA funds. By doing so you will receive maximum coverage under plan. You may use your Horizon *MyWay* HSA to pay for qualified medical expenses as outlined the IRS. Once the deductible is met, covered health expenses are paid as outlined in this section.

IN-NETWORK BENEFITS

You can benefit most from NJ DIRECT HDHP when you obtain your care from in-network providers. When you are treated in-network, you are covered for treatment of illness or injury in addition to well-care and preventive services.

With exception of preventive services, all covered in-network services are subject to the annual deductible and coinsurance. The coinsurance for in-network services is 80 percent of the plan allowance. This means that the plan pays 80 percent of the plan allowance for eligible services, and you are responsible for the remaining 20 percent. Once the in-network out-of-pocket annual maximum of \$1,000 single or \$2,000 other coverage levels is reached, NJ DIRECT HDHP will pay 100 percent of the cost of covered in-network services.

In-network care is provided through a network of providers that includes internists, general practitioners, specialists, pediatricians, and hospitals. No referrals are needed for visits to a specialist. If the physician participates in the Horizon BCBSNJ Managed Care Network, eligible services will be covered at the in-network level of benefits. Members living or accessing services outside of New Jersey can utilize physicians participating in the national BlueCard® PPO Network to receive in-network benefits.

If the physician does not participate in the Horizon BCBSNJ Managed Care Network or the national network, the services will be considered out-of-network. Contact your doctor to see if he or she participates in the Horizon BCBSNJ Managed Care or national BlueCard PPO network outside New Jersey. To find current participating physicians in New Jersey contact Horizon BCBSNJ directly at 1-800-414-SHBP or visit: www.horizonblue.com/shbp

OUT-OF-NETWORK BENEFITS

NJ DIRECT HDHP includes an option for using out-of-network providers. When you exercise this out-of-network option, you will be responsible for the deductibles and higher coinsurance of 40 percent based on a reasonable and customary fee schedule and any amount exceeding the reasonable and customary allowances for all services. NJ DIRECT's out-of-network benefits generally do not cover well-care or preventive care (see page 83). The out-of-network determination is based on the participating status of the provider such as the physician, specialist, therapist, hospital/facility rendering the service. For example, if you utilize a non-participating doctor and services are provided at an in-network hospital, the doctor will be paid at the out-of-network level and the hospital will be paid at the in-network level.

NJ DIRECT will pay 60 percent of the reasonable and customary allowance for eligible out-of-network charges. You are required to pay the remaining 40 percent of the allowance, as well as the difference between the allowance and an out-of-network provider's charges, if applicable. When your out-of-network, out-of-pocket amount for the year totals \$2,000 single or \$4,000 other coverage levels; the plan will pay 100 percent of the reasonable and customary allowance for eligible services. You are required to pay the remaining percentage of the reasonable and customary allowance, as well as the difference between the allowance and the provider's charge, if applicable.

OUT-OF-POCKET MAXIMUMS

For reference, the in-network and out-of-network out-of-pocket limits are noted below:

NJ DIRECT HD1500 and NJ DIRECT HD4000

<u>In-Network</u> Out-of-Pocket Limit:	\$1,000: Single
	\$2,000: Member & Spouse/Partner, Parent & Child(ren), or Family
<u>Out-of-Network</u> Out-of-Pocket Limit:	\$2,000: Single
	\$4,000: Member & Spouse/Partner, Parent & Child(ren), or Family

After meeting the deductible, you are required to pay a percentage of the allowance as well as the difference between the allowance and an out-of-network provider's charges, if applicable. When your out-of-pocket amount for the year reaches the in-network or out-of-network out-of-pocket maximum, the Plan will pay 100 percent of the reasonable and customary allowance for eligible services. For out-of-network services, the member is also responsible for any amount above the reasonable and customary allowance. Expenses for ineligible services, charges in excess of the reasonable and customary allowance and services not authorized and determined to be ineligible do not count toward the out-of-pocket maximum.

HORIZON *MyWay* HSA

A Health Savings Account (HSA), called Horizon *MyWay* HSA, is available to all NJ DIRECT HDHP subscribers. HSAs are a type of personal savings account funded by the subscriber, employer (NJ DIRECT HD1500 only) or both. Horizon *MyWay* HSA funds may be used to pay for **qualified medical expenses** including prescription drugs, as outlined by the IRS.

Horizon BCBSNJ selected ACS | BNY Mellon as the preferred HSA administrator and banking partner for the Horizon *MyWay* HSA. After a Horizon *MyWay* HSA personal account is established, ACS | BNY Mellon will administer the account and work closely with the Horizon BCBSNJ Member Services team to address any questions or concerns. The subscriber is responsible for managing the personal account and playing an active role with the day to day decisions that affect covered health plan expenses.

Horizon *MyWay* HSA members are encouraged to take an active role in their health care, and to use HSA funds wisely by making good health care decisions. NJ DIRECT HDHP members have the flexibility to choose whether to receive care in-network or out-of-network. To get the most from the health plan and limit out-of-pocket expenses, in-network care is encouraged. Participating provider information is available online at www.horizonblue.com/shbp

My Health Manager powered by WebMD® is also available online. *My Health Manager* puts a wealth of health information at your fingertips, including personalized health risk assessments, health news, and information about thousands of health conditions. *My Health Manager* also provides health improvement programs for weight loss, smoking cessation, and much more.

Things you should know about the Horizon *MyWay* HSA:

- HSA funds can be used to meet the annual deductible, to cover applicable coinsurance after the deductible is met, to pay for eligible medical expenses not covered by NJ DIRECT HDHP or to save for future medical expenses.
- The subscriber owns the funds in their Horizon *MyWay* HSA. If the funds are not used, they remain with the subscriber.
- The subscriber, employer or both can make contributions to a personal HSA, and contributions to the HSA are free from federal tax.
- Horizon *MyWay* HSA funds are held in an interest bearing checking account and accrue interest tax free. Any interest gained from the HSA belongs to the subscriber.

- Once the account reaches a balance determined by the financial institution, funds can be invested in a variety of mutual funds.
- HSA funds are portable which means that the subscriber can access the account regardless of a change of employer, age or marital status.
- HSA funds **roll over** from one year to the next.
- HSA contributions must stop once the subscriber or covered dependent enroll in Medicare.

Horizon MyWay Welcome Materials

A welcome kit is issued by ACS | BNY Mellon following enrollment in NJ DIRECT HDHP. The Master Signature Card, included in the welcome kit, can be completed and returned to ACS | BNY Mellon to open the HSA. As an alternative, the subscriber may complete the e-signature process to open their HSA following the process outlined in the welcome letter. The completed Master Signature Card is required to issue a checkbook. Once this Master Signature Card is received and processed, a personal HSA checkbook will be issued. A Horizon MyWay Visa/Debit Card is issued regardless of the method used to open the HSA. The checkbook and Visa/Debit card can be used to pay for **qualified medical expenses** from the HSA account once the account is open and funded.

COORDINATION OF BENEFITS

For group plans that have a Coordination of Benefits provision, the following rules determine which plan is primary.

- If you, the active employee, are the patient, NJ DIRECT is primary for you. If your spouse/partner is the patient, and covered under a health plan provided through his or her employer as an active employee, that plan is the primary plan for them.
- If a member has coverage as an active employee and additional coverage as a retiree the coverage through active employment is primary to retiree coverage.
- When Medicare is involved (except for ESRD; see page 11), the benefits of the plan that covers an active employee and/or his or her dependents will be considered primary before the benefits of a plan that covers a laid-off or a retired employee and his or her dependents.
- If a dependent child is the patient and is covered under both parents' plans, the following birthday rule will apply.

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary plan for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

This birthday rule regulation affects all carriers and all contracts which contain Coordination of Benefits provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

- If two or more plans cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order.
 - ✓ The plan of the parent with custody is primary; followed by
 - ✓ The plan of the spouse/partner of the parent with custody of the child; then
 - ✓ The plan of the parent not having custody of the child.
- If it has been established by a court decree — Qualified Medical Child Support Order (QMCSO) — that one parent has responsibility for the child's health care expenses, then the plan of that parent is primary.
- If none of the rules listed above determine the order of benefits, the plan that has covered the patient for the longer period is the primary plan.

NJ DIRECT will provide its regular benefits in full when it is the primary plan. As a secondary plan, NJ DIRECT will provide reimbursement up to its regular benefit which when added to the benefits under other group plans will not exceed 100 percent of the member's liability.

Please note: The Coordination of Benefits rules described above may change if Medicare is involved. Please refer to the Medicare sections on page 6 and page 9 for more information.

GENERAL BENEFITS

This section lists the general treatments, services, and supplies that NJ DIRECT will consider. Expenses for these services or supplies are subject to reasonable and customary allowances; medical need and appropriate level of care; utilization review; the Schedule of Services and Supplies; and benefit limitations and exclusions. A “Summary Schedule of Services and Supplies” is on page 73 for your reference. Select services require precertification (see page 14 for details). If a service is not listed, please contact Horizon BCBSNJ directly to find out if it is covered.

The fact that an item or service is not listed below, does not automatically make the service or item covered under NJ DIRECT.

Acupuncture

Acupuncture treatment is covered when the services are for **a diagnosis related to pain management** and are rendered by a Licensed Acupuncturist or Licensed Medical Doctor (M.D., D.O.). Acupuncture treatment is subject to maintenance and supportive care provisions.

Examples of acupuncture services that are **not** eligible under NJ DIRECT include weight loss and smoking cessation.

Alcohol and Substance Abuse Treatment

Magellan Behavioral Health is responsible for the management of your behavioral health benefit including treatment for both mental/nervous conditions and alcohol/substance abuse at all levels of care: inpatient, partial hospitalization, residential, intensive outpatient (IOP), individual, and group outpatient treatment.

NJ DIRECT covers the treatment of alcohol and substance abuse the same way it would any other illness if treatment is prescribed by an eligible provider and it is deemed to be medically needed and at the appropriate level of care. Precertification is required for all inpatient admissions and for some specialty care including Intensive Outpatient (IOP) Treatment and Office Based Opioid Treatment (in-network and out-of-network) as noted on page 14. The precertification process will determine if the treatment to be provided is medically appropriate and at the most appropriate level of care to fit your behavioral health needs. Alcohol and substance abuse treatment determinations are supported by the American Society of Addictions Medicine (ASAM) guidelines. The precertification process through Magellan Behavioral Health is available 24 hours-a-day, 7 days-a-week by calling 1-800-991-5579.

In addition to helping you navigate the precertification process, Magellan Behavioral Health can help you find a provider, support your treatment, and manage the services you are receiving to ensure that they are appropriate for your behavioral health needs and supported by the ASAM criteria. For additional information or assistance regarding scheduled or emergency treatment related to alcohol or substance abuse, you or your provider may call 1-800-991-5579.

Precertification is not required for routine, office based outpatient alcohol and substance abuse services incurred on or after January 1, 2013. Services may be reviewed at any time to determine the medical necessity of the level of care being provided. Magellan may contact your treating provider to discuss your treatment and the authorization requirement that will be applied. Authorization is required for coverage of any treatment that Magellan

determines is not consistent with usual treatment practices for your condition based on the frequency of sessions, duration of treatment or other factors. You will be advised if a medical necessity review is conducted and services will require review and authorization. The absence of precertification or authorization, when required, prior to services being rendered, may result in the denial of payment for services.

Inpatient or outpatient treatment may be furnished as follows:

- Care provided in a state licensed health care facility.
- Care provided in a licensed detoxification facility.
- Care provided at a licensed and state approved residential treatment facility, under a plan which meets minimum standards of care.
- Care provided by an eligible, licensed behavioral health professional. Eligible providers of behavioral health services are Psychiatrists (MD), Licensed Psychologists (PhD), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), and Certified (Psychiatric), Nurse Practitioners working within the scope of their practice.

Allergy Testing and Treatment

Most commonly used methods of allergy testing are covered. However, some methods are subject to medical need at the appropriate level of care and will be reviewed before eligibility can be determined.

Ambulance

Ambulance use for local **emergency** transport to the nearest facility equipped to treat the emergency condition is covered subject to medical need at the appropriate level of care. If emergency air transport is needed, it must be medically necessary and approved by having your physician call Horizon BCBSNJ at 1-800-664-2583.

NJ DIRECT **does not cover** chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel, lodging, or communication expenses of patients, providers, nurses, or family members.

Audiology Services

Audiology services are covered when rendered by a physician or a licensed audiologist, when such services are determined to be medically necessary and at the appropriate level of care. See exclusions for hearing aids and hearing examinations.

Autism or Another Developmental Disability

Chapter 115, P.L. 2009, requires that the SHBP/SEHBP provide:

- Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
- Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability;
- Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals under 21 years of age diagnoses with autism;

- A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

ABA therapy is not eligible for children with developmental diagnoses.

Magellan Behavioral Health must be contacted to precertify ABA services for autistic children.

Horizon BCBSNJ Utilization Management must be contacted for precertification by the provider requesting occupational therapy, speech, and physical therapy services.

Automobile-Related Injuries

NJ DIRECT will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) unless NJ DIRECT has been elected as the primary coverage by or for the employee covered under NJ DIRECT. This election is made by the named insured under the PIP program and affects that member's family members who are not themselves the named insured under another auto policy. NJ DIRECT may be primary for one member, but not for another if the individuals have separate auto policies and have made different selections regarding primacy of health coverage.

If NJ DIRECT is primary to PIP or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions, and limits set forth in your contract and only for those services normally covered under NJ DIRECT.

Please note: If you elect to have NJ DIRECT as primary to PIP, prior notification to NJ DIRECT is not required. Upon receipt of an auto related claim, NJ DIRECT will request the submission of written documentation, such as a copy of your policy declaration page, for verification of your selection.

NJ DIRECT is one of several health insurance plans which provides benefits for automobile related injuries. If the covered employee has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If NJ DIRECT is secondary to PIP, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after PIP has provided coverage, subject to medical need at the appropriate level of care and other provisions, after application of deductibles and coinsurance, or
- The actual benefits that would have been payable had NJ DIRECT been primary.

Biofeedback

Biofeedback to treat a medical or **biologically-based mental illness** diagnosis is covered the same as any other general condition.

Birthing Centers

As an alternative to conventional hospital delivery room care for low-risk maternity patients, NJ DIRECT allows benefits for care in participating birthing centers. Services routinely provided by the birthing centers including prenatal, delivery, and postnatal care, will be covered in full if the delivery takes place at the center. If complications occur during labor, and delivery occurs in an approved hospital because of the need for emergency or inpatient care, this care will also be covered in full. Contact Horizon BCBSNJ at 1-800-414-7427 to identify eligible birthing centers near you.

Blood

Blood, blood products, blood transfusions, and the cost of testing and processing blood are covered. NJ DIRECT does not pay for blood which has been donated or replaced on behalf of the patient.

Breast Reconstruction

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, NJ DIRECT will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Prosthesis(es).
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Physical complications at all stages of the mastectomy, including lymphedemas.

Chiropractic Services

There is a 30-visit per calendar year benefit maximum for chiropractic services. The chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and must fall within the scope of practice of a chiropractor in the state in which he or she is practicing. Chiropractic services are subject to a medical necessity review process.

Congenital Defects

Surgical procedures that are necessary to correct a congenital birth defect which significantly impairs function are covered.

Dental Care

NJ DIRECT provides benefits for the removal of bony impacted molars, and will pay for the treatment of accidental injuries, and treatment for mouth tumors if medically necessary.

NJ DIRECT may provide coverage for the treatment of accidental dental injuries. You must have been covered by NJ DIRECT at the time the injury occurred. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice.

The treatment and replacement must occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit **may be** extended. Breaking a tooth while chewing on food is not considered an accidental dental injury. Stress fractures in teeth are very common and generally undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered a dental service and not eligible for reimbursement.

Dental services required as the result of medical conditions or medical services rendered such as: radiation, chemotherapy and long term use of prescription drugs are not eligible. These dental services should be submitted to your Dental Plan.

Hospital and anesthesia charges incurred for dental services that are medically needed and at the appropriate level of care are covered for severely disabled members and children when convincing documentation is submitted in advance for the medical need for the hospitalization/anesthesia services. Charges for the actual dental procedures would not be eligible for benefits.

Orthodontia is **not** covered.

Diabetic Self-Management Education

Benefits, limited to four visits per year, are included for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the member's condition.

Benefits for self-management education and education relating to diet shall be limited to medically necessary visits upon:

- The diagnosis of diabetes;
- The diagnosis by a physician or nurse provider/clinical nurse specialist of a significant change in your symptoms or conditions which necessitate changes in your self-management; and
- Determination by a physician or nurse provider/clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education is covered when provided by:

- A physician, nurse provider, or clinical nurse specialist;
- A health care professional such as a registered dietitian that is recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
- A registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Benefits are provided for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse provider/clinical nurse specialist:

- Blood glucose monitors
- Test strips for glucose monitors and visual reading and urine testing strips
- Insulin
- Injection aid cartridges
- Syringes
- Insulin pumps
- Insulin infusion devices
- Alcohol wipes

Dialysis

Dialysis is covered when the services are provided and billed by an eligible hospital, by a freestanding dialysis center, or by an eligible home health care agency. The facility must make arrangements for training, equipment rental, and supplies on behalf of the patient. Home dialysis will be considered when there is documented evidence that the services cannot be performed in an outpatient facility. Ambulance transportation/invalid coach service to and from dialysis sessions is not eligible for coverage.

Durable Medical Equipment and Supplies

Charges for the rental of durable medical equipment needed for therapeutic use are covered. NJ DIRECT may cover the purchase of such items when it is less costly and more practical than renting such items. NJ DIRECT does not cover the rental or purchase of any items that do not fully meet the definition of durable medical equipment. For in and out-of-network services it is recommended that costly durable medical equipment be approved by Horizon BCBSNJ prior to purchase.

NJ DIRECT also covers eligible supplies including surgical dressings, blood and blood plasma, artificial - limbs, larynx and eyes, casts, Inherited Metabolic Disease medical food, certain non-standard infant formula (under one year of age), splints, trusses, braces, crutches, respirator oxygen and rental of equipment for its use.

Deluxe models of durable medical equipment items such as, but not limited to, wheelchairs are not eligible for benefits.

Emergency Medical Services

A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, Horizon BCBSNJ shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered.

If you find yourself in an emergency situation and notification prior to treatment is not reasonably possible, go directly to the nearest emergency facility. All such treatment received during the first 48 hours after the onset of the medical emergency will be eligible for in-network benefits, regardless of whether such treatment is received in or out of the service area or whether such treatment is furnished by a network provider.

Urgent and After Hours Care

Urgent care is medically necessary care for an unexpected illness or injury that should be treated within 24 hours but is not life-threatening. It is medical care you can safely postpone until you can call a physician. Examples of urgent care include fever, earache, cuts, sprains, and minor burns. In instances like these, call your physician first for instructions. If your physician determines your situation is a medical emergency, he or she will refer you directly to an emergency facility. If it is not a medical emergency, your physician will tell you how to treat the problem yourself or make an appointment to see you. Your physician or a covering physician should be available 24 hours a day, every day.

Contact your physician for after hours care or care that is required at night or on a weekend or holiday. Again, your physician will provide instructions on how to treat your problem.

Emergency Room

Each time the member uses the hospital emergency room, the member must pay a copayment. If the member is admitted within 24 hours, the copayment amount is waived. There may also be additional medical charges for out-of-network emergency rooms that may not be reimbursed in full.

Federal Government Hospitals

NJ DIRECT will pay for eligible charges in hospitals operated by the United States government (Veterans Administration) as if they were member hospitals, regardless of their location, for eligible charges for nonmilitary conditions.

NJ DIRECT will pay hospitals operated by the United States government for nonmilitary patients (i.e., patients other than military retirees and their dependents and dependents of active duty military personnel) for eligible charges only if:

- Services are for treatment on an emergency basis for accidental injury from an external cause; or
- Services are provided in a hospital located outside of the United States and Puerto Rico.

Gynecological Care and Examinations

Gynecological care and examinations are eligible. NJ DIRECT provides coverage for one routine gynecological examination per year which may include one routine Pap smear, when provided by a gynecologist.

Hearing Aids

Coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for covered members who are 15 years old or younger. Coverage is provided for the purchase of a hearing aid for each hearing impaired ear once in a 24 month period, when it is medically necessary and prescribed by a licensed physician or audiologist. Benefits during each 24 month period are limited to the cost of the hearing aid up to \$1,000 for each hearing impaired ear. If a higher priced hearing aid is selected, the member is responsible for the amount that is greater than \$1,000.

Hemophilia Treatment

Hemophilia treatment is covered in an inpatient facility or outpatient facility. Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility.

Home Health Care

Home health care services and supplies are covered only if furnished by providers on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis. Precertification is required for these services.

The home health care plan must be established in writing by the member's provider within 14 days after home health care starts and it must be reviewed by the member's provider at least once every 30 days.

Eligible home health services (subject to exclusions) provided by a home health care agency include:

- Part-time skilled nursing services provided by or under the supervision of a registered professional nurse (R.N.).
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Related treatment and services eligible for hospital benefits, except drugs and administration of hemodialysis.
- Medical social services or part-time services by a home health care aide during the period when you are receiving eligible skilled nursing care, physical therapy, or speech therapy services.

A prior inpatient hospital stay is not required to qualify for home health care agency benefits but the patient must be homebound and require skilled nursing care under a plan prescribed by an attending physician.

NJ DIRECT **does not** cover:

- Services furnished to family members, other than the patient.
- Services provided by a companion.
- Services and supplies not included in the home health care plan.
- Nursing home care or care that is **maintenance care**, supportive care, care to treat deficiencies that are developmental in nature or are primarily **custodial care** in nature.

Hospice Care Benefits

Benefits for hospice care must be provided according to a physician prescribed course of treatment approved by NJ DIRECT with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered:

- Part-time professional nursing services of an R.N. or L.P.N.

- Home health care aide services provided under the supervision of an R.N.
- Medical care rendered by a hospice care program physician.
- Therapy services (including speech, physical and occupational therapies).
- Diagnostic services.
- Medical and surgical supplies.
- Durable medical equipment.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 10 days for respite care.
- Inpatient acute care for related conditions.
- Medical social services.
- Psychological support services to the terminally ill patient.
- Family counseling related to the Eligible Person's terminal condition.
- Dietician services.
- Inpatient room, board and general nursing services for related conditions.

No benefit consideration will be given for any of the following hospice care benefits:

- Medical care rendered by the patient's private physician (would be paid separately under the plan).
- Volunteer services.
- Pastoral services.
- Homemaker services.
- Food or home-delivered meals.
- Non-authorized private-duty nursing services.
- Dialysis treatment.
- Bereavement counseling.

Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients. For more information on hospice care, please call Horizon BCBSNJ at 1-800-414-7427.

Immunizations

Immunizations provided by an in-network physician are covered under NJ DIRECT unless they are for travel outside the country or work-related. Well-child immunizations for children less than 12 months of age are the only immunizations allowed out-of-network.

Infertility Treatment

NJ DIRECT will follow the New Jersey State Mandate for Infertility.

Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy (including microsurgical sperm aspiration); laboratory tests; sperm washing or preparation; diagnostic evaluations; assisted hatching; fresh and frozen embryo transfer; ovulation induction; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; zygote intrafallopian transfer (ZIFT); artificial insemination; intracytoplasmic sperm injection (ICSI); and the services of an embryologist. This benefit includes diagnosis and treatment of both male and female infertility.

Eligibility Requirements

Infertility services are covered for any abnormal function of the reproductive systems such that you are not able to:

- Impregnate another person;
- Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- Carry a pregnancy to live birth.

In vitro fertilization, gamete transfer and zygote transfer services are covered only:

- If you have used all reasonable, less expensive and medically appropriate treatment and are still unable to become pregnant or carry a pregnancy;
- Up to four completed egg retrievals combined, per lifetime (including those covered under prior plans, but not those provided at your expense); and
- If you are 45 years old or younger.

Covered Expenses

- Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist.
- Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met.
- Intracytoplasmic sperm injections.
- In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate.
- Prescription medications, including injectable infertility medications, are covered under the SHBP/SEHBP's Prescription Drug Plans. Private freestanding prescription drug plans arranged by local employer groups are required to be comparable to the SHBP/SEHBP Prescription Drug Plans and must provide coverage for infertility medications for covered members and donors.

- Ovulation induction.
- Surgery, including microsurgical sperm aspiration.
- Artificial Insemination.
- Assisted Hatching.
- Diagnosis and diagnostic testing.
- Fresh and frozen embryo transfers.

Exclusions

The following are specifically ***excluded*** infertility services:

- Reversal of male and female voluntary sterilization.
- Infertility services when the infertility is caused by or related to voluntary sterilization.
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist.
- Cryopreservation is not a covered benefit.
- Any experimental, investigational, or unproven infertility procedures or therapies.
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract.
- Ovulation kits and sperm testing kits and supplies.
- In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older.
- Costs associated with egg or sperm retrieval not related to an authorized IVF procedure.

Lead Poisoning Screening and Treatment

Lead poisoning screening (in-network only). Treatment is eligible In-Network and Out-of-Network. No copayment applies to in-network screenings.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center. For information regarding the eligibility of certain centers, please call Horizon BCBSNJ at 1-800-414-7427.

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease require precertification. When intravenous therapy is determined to be medically appropriate, the supplies, cost of

the drug, and skilled nursing visits will be covered services. If services are not precertified and are determined not to be medically necessary, the services will not be covered.

Mammography

Covers mammograms provided to a female member. Coverage is provided as follows:

- One baseline mammography at any age.
- Age forty and older, one screening mammography per year.

Mastectomy Benefits

A hospital stay of at least 72 hours following a modified radical mastectomy and a hospital stay of at least 48 hours is covered following a simple mastectomy unless the patient, in consultation with his physician, determines that a shorter length of stay is medically needed and at the appropriate level of care.

Maternity/Obstetrical Care

Medical care related to childbirth includes the hospital delivery and hospital stay for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section if the attending provider determines that inpatient care is medically needed and at the appropriate level of care.

Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child are covered as part of the obstetrical care benefits.

NJ DIRECT also covers birthing center charges made by a provider for pre-natal care, delivery, and post-partum care in connection with a member's pregnancy.

Professional charges, billed by an eligible provider, related to the prenatal care, delivery and postnatal care for home birth are covered.

Note: Providers do not routinely perform home births. The availability of a provider who performs home births is not guaranteed.

Maternity/Obstetrical Care for Child Dependents

In some instances, NJ DIRECT will pay bills related to the birth of a grandchild. In order for benefits to be available, the mother must be enrolled as a covered child.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for dependent coverage of the grandchild only if he or she obtains legal custody of the child.

Mental or Nervous Conditions (Biologically and Non-Biologically Based)

Magellan Behavioral Health is responsible for the management of your behavioral health benefit including treatment for mental/nervous conditions and alcohol/substance abuse provided at all levels of care: in-patient, partial hospitalization, residential, intensive outpatient (IOP), and individual or group outpatient treatment. Eligible providers of behavioral health care are Psychiatrists (MD), Licensed Psychologists (PhD), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), and Certified (Psychiatric), Nurse Practitioners working within the scope of their practice.

Precertification (prior to treatment) is required for all admissions and for some specialty services (in-network and out-of-network) including electroconvulsive therapy, Repetitive Transcranial Magnetic Stimulation, biofeedback, psychological testing, and Intensive Outpatient (IOP) treatment. The precertification process will determine if the treatment to be provided is medically appropriate and at the most appropriate level of care to fit your behavioral health needs. Medical necessity determinations for mental health services are supported by the Magellan Behavioral Health Medical Necessity criteria.

Precertification is not required for routine, office based outpatient mental health services incurred on or after January 1, 2013. Services may be reviewed at any time to determine the medical necessity of the level of care being provided. Magellan may contact your treating provider to discuss your treatment and the authorization requirement that will be applied. Authorization is required for coverage of any treatment that Magellan determines is not consistent with usual treatment practices for your condition based on the frequency of sessions, duration of treatment or other factors. You will be advised if a medical necessity review is conducted and services will require review and authorization.

The precertification process through Magellan Behavioral Health is available 24 hours-a-day, 7 days-a-week by calling 1-800-991-5579. In addition to helping you navigate the precertification process, Magellan Behavioral Health can help you find a provider, support your treatment and manage the services you are receiving to ensure that they are appropriate for your behavioral health needs and are supported by Magellan Behavioral Health Medical Necessity criteria. The absence of precertification or authorization, when required, prior to services being rendered, may result in the denial of payment for services.

Nutritional Counseling (In-Network Only)

NJ DIRECT allows three visits per year for nutritional counseling that is medically needed and at the appropriate level of care.

Occupational Therapy (See Physical Therapy)

Organ Transplant Benefits

Pre-approved services and supplies for the following types of transplants are covered:

- Lung
- Liver
- Heart
- Pancreas
- Certain autologous bone marrow
- Cornea (pre-approval is not required in or out-of-network)
- Kidney (pre-approval is not required in or out-of-network)

Benefits only include surgical, storage and transportation services of the organ which are directly related to the donation and billed for by the hospital.

Pain Management

Pain management services are subject to current medical guidelines and policies. Pain management therapy administered by a licensed physician must be supported by a

comprehensive evaluation of the patient and documentation of the rationale for treatment. The treatment of pain is multifaceted and may include therapeutic exercises, activity modification, physical therapy, occupational therapy, pharmacological interventions, behavioral health interventions, therapeutic and/or surgical interventions. Treatment may not achieve complete elimination of a patient's pain. In such cases, an increase in a patients' level of function and teaching the patient strategies to cope with residual pain will be the goal. If treatment offers no appreciable improvement in the patient's condition further services may be considered maintenance and/or supportive care and will not be eligible for reimbursement.

Horizon BCBSNJ contracts with CareCore National LLC to review and authorize pain management services. Monitored anesthesia rendered as part of pain management services must also be authorized. Participating physicians will obtain prior authorization on your behalf. If you are using a non-participating provider, it is your responsibility to ensure that authorization is obtained before services are rendered. Your physician can contact CareCore at 1-866-241-6603 to request authorization. If you or your physician do not obtain prior authorization for pain management services, those services will not be eligible for reimbursement. If services are rendered without the proper authorization, benefits will be denied. A retroactive benefit review will not be conducted.

Pap Smears

Annual Pap smears provided by your participating OB/GYN are covered at the in-network level of benefits. This benefit is limited to one Pap smear per year unless additional tests are medically needed and at the appropriate level of care for diagnostic purposes. An annual Pap smear provided out-of-network is covered, subject to any deductible and coinsurance.

Patient Controlled Analgesia (PCA)

Patient Controlled Analgesia (PCA) is covered when it is medically appropriate, prescribed by a medical doctor, and provided under the guidance of one of the following:

- Doctor;
- Anesthesiologist; or
- Approved home care agency.

Physical Therapy/Occupational Therapy

Therapy that is medically needed and at the appropriate level of care is covered based on one session per day. A session of therapy is defined as up to one hour of therapy (treatment and/or evaluation) or up to three therapy modalities provided on any given day.

Physicals (In-Network Only)

One routine physical examination for you and your eligible dependents is covered in-network each year. In-network services that are considered preventive care under the Patient Protection and Affordable Care Act will be covered with **no** out-of-pocket cost (no copayment) if you receive the services from a participating health care professional and the sole reason for the visit is to receive the preventive services as denoted by the procedure and diagnosis code reported on the claim.

Physicals for work related purposes, **other than** employer mandated physical examinations that are a prerequisite for participation in an employer mandated physical fitness test

required as a condition of continuing employment, sports, or other similar reasons are **not** covered.

Pre-Admission Hospital Review (In-Network and Out-of-Network)

All non-emergency hospital and other facility admissions must be reviewed by Horizon BCBSNJ before they occur. You or the network hospital or your provider must notify Horizon BCBSNJ and request a Pre-Admission Review by phone or facsimile. Horizon BCBSNJ must receive the notice and request at least 5 business days or as soon as reasonably possible before the admission is scheduled to occur. For a maternity admission, such notice must be given to Horizon BCBSNJ at least 60 days before the expected date of delivery, or as soon as reasonably possible, to obtain in-network benefits.

Pre-Admission Testing Charges

Pre-admission diagnostic X-ray and laboratory tests needed for a planned hospital admission or surgery are covered. NJ DIRECT only covers these tests if the tests are done on an outpatient or out-of-hospital basis within seven days of the planned admission or surgery.

However, NJ DIRECT does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the member's health.

Prostate Cancer Screening (In-Network Only)

One routine office visit per year is covered for adult members, including a digital rectal examination and a prostate-specific antigen test for adult male members over the age of 40.

Scalp Hair Protheses

A benefit maximum of \$500 in a 24 month period, per person, is covered for scalp hair protheses (wig) prescribed by a doctor, only if they are furnished in connection with hair loss resulting from:

- Treatment of disease by radiation or chemicals;
- Alopecia Universalis (totalis); or
- Alopecia Areata.

Second Surgical Opinion

NJ DIRECT provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedure. NJ DIRECT will pay for one consultation by a qualified specialist physician.

If the second opinion specialist does not confirm the need for surgery, NJ DIRECT will provide coverage for one additional consultation if requested by the patient. NJ DIRECT also will provide coverage for any diagnostic X-rays, laboratory tests, or diagnostic surgical procedures required by the physicians performing the consultations.

Shock Therapy Benefits

NJ DIRECT provides benefits for electroshock treatments, insulin shock treatments, and other similar treatments. Benefits are also payable for anesthesia in connection with the shock treatment and for all other eligible services performed on that day for the disorder.

Skilled Nursing Facility Charges

Room and board, including diets, drugs, medicines and dressings, and general nursing services in a skilled nursing facility are covered.

For Medicare Primary Members — the eligible benefit days run concurrently with Medicare eligible days. Once Medicare days are exhausted and NJ DIRECT becomes primary, Horizon BCBSNJ will review continuing services for medical appropriateness and eligibility. Precertification is required after Medicare benefits are exhausted or if Medicare does not allow benefits.

Speech Therapy Benefit

Speech therapy services provided by a qualified speech therapist are covered only as follows:

- **To restore speech** after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak.
- To develop or improve speech after surgery to correct a defect that existed at birth and impaired the ability to speak or would have impaired the ability to speak.

Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed are not covered except for Autism and Pervasive Development Disorder (PDD).

Speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

Surgical Services (Out-of-Network)

- **Multiple Procedures**

If multiple procedures are performed during the same operative session, the procedure with the highest Relative Value Unit (RVU) will be considered the primary procedure and the full reasonable and customary allowance will be allowed for that primary procedure minus any applicable member deductible and coinsurance liability. The RVU associated with the procedure codes represents the time and skill involved in the performance of the procedure. All eligible additional procedures performed in the same operative session will be considered secondary procedures that are paid at 50 percent of the reasonable and customary allowance.

- **Bilateral Procedures**

Bilateral procedures will be paid at 150 percent of the reasonable and customary allowance. Services qualify as bilateral when anatomically there are two specific body parts which are being operated upon during the same surgery such as ears,

eyes, knees, breasts, and kidneys. A lesion on the right arm and a lesion on the left arm would not qualify as bilateral since the skin is one body organ.

- **Reasonable and Customary Allowances (for Out-of-Network Services)**

The Plan covers only reasonable and customary allowances, which are determined by the FAIR Health benchmark charge data fee schedule or a similar nationally recognized database. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.

- Non-network assistant surgeons will be paid at the out-of-network level of benefits and reimbursed based on 16 percent of the surgical allowance if the service is deemed medically appropriate.

Temporomandibular Joint Disorder (TMJ) and Mouth Conditions

Medical and surgical services performed for the treatment of the jaw are covered. Services in relation to the teeth in any manner are excluded. Charges for doctor's services or X-ray examinations for a **mouth condition** are not eligible.

Charges for dental or orthodontic services for a TMJ diagnosis are not eligible. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of TMJ or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring or repositioning of teeth and dental implants.

Vision Care Benefits

NJ DIRECT covers an annual routine eye examination by an in-network ophthalmologist or optometrist. There are no benefits available for frames, lenses, or contact lenses. Contact lens fitting examinations are also not covered. There is no out-of-network preventive vision care benefit.

Any visits to an ophthalmologist or optometrist for the diagnosis and treatment of a condition will be eligible at the in-network and out-of-network level of benefits.

CHARGES NOT COVERED BY NJ DIRECT

Even though a service or supply may not be described or listed in this handbook, that **does not** make the service or supply eligible for a benefit under this plan.

The following services and supplies **are not covered**:

- Automobile accident-related injuries or conditions: Unless NJ DIRECT has been chosen by the member as primary, NJ DIRECT does not pay for the treatment of injuries or conditions related to an automobile accident if automobile insurance could have or should have covered the treatment. This exclusion applies to, but is not limited to:
 - ✓ Existing motor vehicle insurance contracts;
 - ✓ Motor vehicle contracts that were purchased but have since lapsed;

- ✓ Motor vehicle insurance coverage that should have been purchased; and
- ✓ Failure to make timely claims under a motor vehicle insurance policy.
- Autopsy.
- Car Seats.
- Care that is primarily custodial in nature.
- Chair and stair lifts.
- Charges above the reasonable and customary allowance or out-of-network plan allowance.
- Charges billed by an Assisted Living Facility.
- Charges for services or supplies not specifically covered under the plan.
- Charges for services rendered by a member of the patient's immediate family (including you, your spouse/domestic partner, your child, brother, sister, or parent of you or your spouse/domestic partner).
- Charges for services rendered by a Birth Doula.
- Charges for the completion of a claim form, photocopies of pertinent medical information, or medical records.
- Charges in connection with an external review of an appeal or complaint.
- Charges incurred prior to or in the course of a legal adoption.
- Charges that should have been paid by Medicare, if Medicare coverage had been in effect.
- Cosmetic procedures — charges connected with curing a condition by cosmetic procedures. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in NJ DIRECT. Among the services that are not covered are:
 - ✓ Removal of warts, with the exception of plantar warts;
 - ✓ Spider vein treatment; and
 - ✓ Plastic surgery when performed primarily to improve the person's appearance.
- Costs beyond the embryo transfer for a surrogate are not eligible.
- Court ordered services or treatments.
- Coverage for expenses incurred for behavioral interventions (ABA) therapy for individuals diagnosed with autism who are 21 years of age or older.
- Deluxe models of wheelchairs and other durable medical equipment.
- Dental Care – other than accidental injury.
- Durable medical equipment or supplies which are specifically excluded from coverage. To determine which equipment or supplies are eligible for coverage, call 1-800-414-SHBP (7427).

- Educational or developmental services or supplies, or educational testing. This includes services or supplies that are rendered with the primary purpose being to provide the person with any of the following:
 - ✓ Training in the activities of daily living. This does not include training directly related to the treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.
 - ✓ Instruction in scholastic skills such as reading and writing.
 - ✓ Preparation for an occupation.
 - ✓ Treatment for learning disabilities.
 - ✓ To promote development beyond any level of function previously demonstrated.
 - ✓ Assessments/testing of academic function.
 - ✓ Services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient regardless of where services are rendered. Rehabilitation programs that are primarily educational or behavioral in nature.
- Expenses for wilderness rehabilitation programs, diabetic camps, or other similar camps or programs.
- Experimental or investigational services or supplies and charges in connection with such services or supplies (see page 18).
- Eye care including:
 - ✓ Out-of-network examinations to determine the need for glasses or lenses of any type, typically known as refraction examinations regardless of the diagnosis.
 - ✓ Lenses of any type except initial lens replacement for loss of the natural lens after cataract surgery.
 - ✓ Eyeglasses and contact lenses regardless of the diagnosis, including but not limited to Kerataconus.
 - ✓ Low vision aids.
- Eye surgery, such as radial keratotomy, Lasik procedures, or other refractive procedures performed for any reason.
- Foot conditions — charges for doctor's services for:
 - ✓ A weak, strained, flat, unstable, or imbalanced foot, metatarsalgia, or a bunion. However, this exclusion does not apply to an open cutting operation.
 - ✓ One or more corns, calluses, or toenails. This exclusion does not apply to a charge for the removal of part or all of a nail root and services connected with treating metabolic or peripheral vascular disease.
- Government plan charges including a charge for a service or supplies:
 - ✓ Furnished by or for the United States government;

- ✓ Furnished by or for any government, unless payment is required by law; or
 - ✓ To the extent that the service or supply, or any benefit for the charge, is provided by any law or government plan under which the member is or could be covered. This applies to Medicare and "no-fault" medical and dental coverage when required in contracts by a motor vehicle law or similar law.
- Health Clubs and Gym Memberships.
 - Hearing aids of any type (except as described under "Hearing Aids" on page 33).
 - Hearing examinations to determine the need for hearing aids or the need to adjust a hearing aid, no matter what the cause of the hearing loss, except for members who are 15 years old or younger (see page 33).
 - Herbal, Alternative or Complementary medicine treatments.
 - Hot tubs, saunas, Jacuzzis or pools of any type.
 - Hypnosis.
 - Immunizations and preventive vaccines when out-of-network (see exceptions under "Immunizations" on page 35).
 - Incidental Procedures — certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is considered part of the primary procedure in order to successfully complete service.
 - Legal fees.
 - Maintenance care — care that has reached a level where additional services will not appreciably improve the condition.
 - Marriage counseling.
 - Medicare services rendered by providers who are not registered with or opt-out of Medicare.
 - Modifications to an auto to make it accessible and/or drivable.
 - Modifications to a home to make it accessible for a disabled/injured person
 - Mouth conditions — charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 91 of the "Glossary" for the definition of a mouth condition.
 - Nursing home care.
 - Over-the-counter supplies, supplements, vitamins, medications, or drugs that do not require a prescription order under Federal law, even if the prescription is written by a physician. These include, but are not limited to, aspirin, vitamins, lotions, creams, oils, formulas, liquid diets, and dietary supplements.

- Personal comfort or convenience items including telephone or television service, haircuts, guest trays, or a private room during an inpatient stay.
- Prescription drug charges or copayments. If your prescription drug plan does not provide benefits for a particular drug, it does not mean that it will be eligible under NJ DIRECT benefits.
- Private Duty Nursing (Inpatient). Private Duty Nursing (PDN) is covered subject to Horizon BCBSNJ medical policy. Authorization is required. PDN is characterized by the performance of skilled services by a licensed nursing professional (RN/LPN) in the member's home typically to take the place of continued in-patient treatment. PDN will be part of a written short term, home care plan leading to the training of the primary care giver(s) to deliver those services once the member's condition is stabilized. Private Duty Nursing is not meant to replace a parent or caregiver, but is meant to provide skilled support to the member at home when such services are medically necessary to properly attend the member.

According to Horizon BCBSNJ medical policy PDN is considered medically necessary for members who are on ventilators when the physician or specialist has agreed to a home care plan, the member meets medical necessity criteria for confinement in a Skilled Nursing Facility and placement of the nurse in the home is done to meet the skilled needs of the member only; not for the convenience of the family caregiver. Upon initial discharge of a ventilator dependent member from an inpatient setting, up to 24 hours PDN per day may be covered for a period of up to three weeks to facilitate transition to home. Thereafter, up to a maximum of 16 hours of PDN per day may be considered medically necessary. Payment for any additional home nursing care is the sole responsibility of the member/family.

- Postage, handling and shipping fees.
- Private rooms in a hospital. If you occupy a private room in a hospital or facility, you must pay the difference between the private room rate and the average semiprivate room rate.
- Preventive care/routine screening — unless otherwise indicated, NJ DIRECT's out-of-network coverage does not provide benefits for services or supplies that are considered to be performed for any of the following:
 - ✓ Routine well-care as part of a routine examination.
 - ✓ Services and supplies that are provided for a diagnosis that does not indicate an illness present at the time the service are rendered.
 - ✓ Services that are considered preventive or screening in nature.

The following services are examples of out-of-network routine services that are **not** covered:

- ✓ All immunizations/vaccinations including well-child immunizations/vaccinations (except for children under 12 months of age).
- ✓ Flu shots/pneumonia vaccines.
- ✓ Well-care annual physicals.

- ✓ Cancer antigen tests that are performed because of a family history. Specific guidelines apply to the eligibility of cancer antigen tests. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.
- ✓ PSA (Prostate Specific Antigen) as part of a routine examination or recommended due to a family history of disease. Specific guidelines apply to the eligibility of PSA for non-routine reasons.
- Repatriation (Returning a traveler to his/her home when unable to continue with travel due to medical reasons).
- Self-or home-testing kits whether prescribed by a doctor or not.
- Services for cosmetic surgery (or complications that result from such surgery) on any part of the body **except** for reconstruction surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury, therapeutic surgery or to correct a congenital defect.
- Services or supplies that are not medically needed and/or not at the appropriate level of care and charges in connection with such services or supplies. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and diagnosis of an illness or injury or make it a covered medical expense.
- Services that are commonly or customarily provided without charge to the patient. Even when the services are billed, NJ DIRECT will not pay if they are usually not billed when there is no coverage available.
- Services and supplies prescribed or provided by an ineligible provider.
- Services or supplies that require prior authorization that are not authorized before services are rendered.
- Services rendered before the effective date of coverage or after the termination of coverage date. However if the covered patient is hospitalized as an inpatient and coverage terminates during the stay, that inpatient stay (as long as otherwise eligible) will be covered through to discharge.
- Services rendered or billed by an Assisted Living Facility.
- Shoes that are not custom molded, are not attached to a brace, or can be purchased without a prescription.
- Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed (Exceptions: Autism and Pervasive Developmental Disorder).
- Sports physicals.
- Supportive care — supportive care is defined as treatment for patients having reached maximum therapeutic benefit in which periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. In some instances therapy may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet it would not be eligible for reimbursement under NJ DIRECT.
- Taxes on services/supplies.

- Telephone consultations or provider charges for telephone calls.
- Transport — Non-emergency transport via ambulance or transport by coach of any kind (by land, air, or water).
- Treatment of injuries sustained while committing a felony.
- War — charges for illness or injury due to an act of war. War means either declared or undeclared, including resistance or armed aggression.
- Weight loss programs such as Jenny Craig, Weight Watchers, and the cost of food associated with them.
- Work-related injury or disease. This includes the following:
 - ✓ Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
 - ✓ Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
 - ✓ Work-related tests, examinations, or immunizations of any kind required by your work.
 - ✓ Work related injuries will not be eligible for benefits under NJ DIRECT before or after your Worker's Compensation carrier has settled or closed your case.

This exclusion does not apply to employer-mandated physical examinations that are a prerequisite for participation in an employer mandated physical fitness test required as a condition of continuing employment. However, such employer mandated physical examinations are covered in-network only.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and NJ DIRECT, you may be subject to prosecution for insurance fraud.

Examples of Non-Covered Services:

Example 1: A physician orders inpatient private duty nursing for a surgery patient. Since, while confined in a hospital, nursing services are provided by the hospital, any charges for private duty nursing will not be paid.

Example 2: A person is studying to become a therapist and is required by the school to enter therapy. The treatment is intended to ensure that the new therapist is well-equipped to work with patients. The treatment is not covered because it is primarily educational.

Example 3: A physician orders a drug that is FDA-approved but is not commonly used to treat the particular condition. If NJ DIRECT determines that the use is experimental, the plan will not pay for the drug.

Example 4: A hospital routinely requires an assistant surgeon or Registered Nurse First Assistant (RNFA) to be present at certain operations. NJ DIRECT will only pay for assistant surgeons/RNFA's that are determined to be medically necessary.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from NJ DIRECT for medical services that are either auto-related or work-related, Horizon BCBSNJ has the right to recover those payments. This means that if you are reimbursed through a settlement, satisfied by a judgment, or other means, you are required to return any benefits paid for illness or injury to NJ DIRECT. The repayment will only be equal to the amount paid by NJ DIRECT.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with Horizon BCBSNJ in recovering any amounts payable. Horizon BCBSNJ may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise NJ DIRECT's rights under this provision, before any benefits are provided under your group's policy;
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which Horizon BCBSNJ may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

SUBROGATION AND REIMBURSEMENT

Benefits payable as a result of any injuries claimed against any person or entity other than this Health Plan are excluded from coverage under this Plan. If benefits are provided by this Plan that are otherwise payable or become payable by any third party action against any person or entity, this Plan is entitled to reimbursement only on the following terms and conditions:

- In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Member's rights of recovery against any person or organization to the extent of the benefits provided ("Member" includes any person receiving benefits hereunder including all dependents). The Member shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Member shall do nothing after loss to prejudice such rights. The Member must cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.
- The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in the preceding paragraph, but only to the extent of the benefits provided by the Plan.

- The subrogation and reimbursement rights and liens apply to any recoveries made by the Member as a result of the injuries sustained, including but not limited to the following:
 - ✓ Payments made directly by a third party, or any insurance company on behalf of a third party, or any other payments on behalf of the third party.
 - ✓ Any payments or settlements, judgment or arbitration awards paid by any insurance company under uninsured or underinsured motorist coverage, whether on behalf of a Member or other person.
 - ✓ Any other payments from any source designed or intended to compensate a Member for injuries sustained as the result of negligence or alleged negligence of a third party.
 - ✓ Any worker's compensation award or settlement.
 - ✓ Any recovery made pursuant to no-fault insurance.
 - ✓ Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Member, whether under comparative negligence or otherwise.

WHEN YOU HAVE A CLAIM

Submitting a Claim (In-Network)

Generally you will not have to submit any claim forms to Horizon BCBSNJ for reimbursement for treatment from a network provider. You will simply pay the provider the required copayment amount and the provider will submit claims directly to Horizon BCBSNJ for the appropriate reimbursement.

Submitting a Claim (Out-of-Network)

If you receive treatment out-of-network, claims must be submitted for reimbursement to:

**Horizon BCBSNJ,
P.O. Box 820
Newark NJ 07101-0820
(1-800-414-SHBP)**

All mental health and substance abuse claims should be mailed to:

**Magellan/NJ DIRECT
P.O. Box 5172
Columbia, MD 21045-5172**

Filing Deadline (Proof of Loss)

Horizon BCBSNJ must be given written proof of a loss for which a claim is made under NJ DIRECT. This proof must cover the occurrence, character, and extent of the loss. It must be furnished **within one year and 90 days of the end of the calendar year in which the services were incurred**. For example, if a service were incurred in the year 2009, you would have until March 31, 2011, to file the claim.

A claim will not be considered valid unless proof is furnished within the time limit shown above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all medical expenses. The itemized bills must include the following:

- Name and address of provider;
- Provider's tax identification number;
- Name of patient;
- Date of service;
- Diagnosis;
- Type of service;
- CPT 4 code; and
- Charge for each service.

Foreign Claims

Bills for services that are incurred outside of the United States must include an English translation and the charge for each service performed. The exchange rate at the time of service should also be indicated on the bill that is submitted for reimbursement.

Filling Out the Claim Form

Be sure to fill out the claim form completely. Include the identification number that appears on your NJ DIRECT identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

MEDICARE CLAIM SUBMISSION

If a member is a New Jersey resident, has Medicare primary coverage, and receives care within New Jersey, claims will be transmitted automatically from the Medicare carrier to NJ DIRECT.

If a member resides in another state and has Medicare primary coverage, the member will have to submit a copy of the *Medicare Explanation of Benefits*, an itemized bill, and a completed NJ DIRECT claim form to Horizon BCBSNJ.

AUTHORIZATION TO PAY PROVIDER

The providers that participate with NJ DIRECT will be paid directly for eligible services. The member will be paid for all services rendered by non-participating providers. Once payment has been made to the member for services rendered, Horizon BCBSNJ will not have to pay the benefit again.

QUESTIONS ABOUT CLAIMS

If you have questions about a hospital claim, hospital benefits, a medical claim, or medical benefits or if you need a claim form, call Horizon BCBSNJ at 1-800-414-SHBP (7427).

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Appeal Procedures" section.

APPEAL PROCEDURES

NJ DIRECT MEDICAL APPEAL PROCEDURE

Member appeals that involve medical judgment made by Horizon BCBSNJ are considered medical appeals. An adverse benefit determination involving medical judgment is (a) a denial; or (b) a reduction from the application of clinical or medical necessity criteria; or (c) a failure to cover an item or service for which benefits are otherwise provided because Horizon BCBSNJ determines the item or service to be experimental or investigational, cosmetic, or dental, rather than medical. Adverse benefit determinations involving medical judgment may usually be appealed up to three (3) times as outlined below:

- **First Level Medical Appeal** – The First Level Medical Appeal of an adverse benefit determination.
- **Second Level Medical Appeal** – The Second Level Medical Appeal of an adverse benefit determination available to you after completing a First Level Medical Appeal.
- **External Appeal** – The third Level Medical Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Medical Appeal. An External Appeal provides you the right to appeal to an Independent Review Organization (IRO).

An overview of the medical appeal procedure is provided below. An NJ DIRECT Medical Appeals Procedure brochure will be provided with every adverse benefit determination involving medical judgment. The brochure provides a comprehensive description of the procedures.

First Level Medical Appeal

First Level Medical Appeals may be submitted in writing or verbally. Verbal appeals may be directed to Horizon BCBSNJ Utilization Management at 1-888-221-6392. Written appeals may be sent to:

**Horizon BCBSNJ
NJ DIRECT Medical Appeals
PO Box 420
Mail Station PP 14E
Newark NJ 07101-0420**

The member, physician, or authorized representative has one (1) year following your receipt of the initial adverse benefit determination letter to request a Medical Appeal.

To initiate a First Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved.
- Member's identification number.
- Date(s) of service.
- Nature and reason behind your appeal.
- Remedy sought.

- Clinical documentation to support your appeal.

First Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard First Level Medical Appeals are reviewed and decided within 15 calendar days of receipt.
- First Level Expedited (urgent and emergent) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon BCBSNJ's receipt of the appeal request.

The member will receive a letter documenting Horizon BCBSNJ's First Level Medical Appeal decision. The letter will include the specific reasons for the determination.

Expedited Review

Horizon BCBSNJ Medical Appeal procedures may be expedited in circumstances involving urgent or emergent care.

First and Second Level Medical Appeals are automatically handled in an expedited manner for all determinations regarding urgent or emergent care, an admission, availability of care, continued stay, or health care services for which the claimant received emergency services but has not been discharged from the facility. Furthermore, if you feel that the Horizon BCBSNJ decision will cause serious medical consequences in the near future, you have the right to an Expedited Medical Appeal. You also have the right to an Expedited Medical Appeal if in the opinion of a physician with knowledge of your medical condition, your condition is as described above or that you will be subject to severe pain that cannot be adequately managed without receiving the denied medical services. Expedited Medical Appeals are initiated by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**.

Second Level Medical Appeals

If you disagree with the First Level Medical Appeal decision, you have one (1) year following receipt of Horizon BCBSNJ's original determination letter to request a Second Level Medical Appeal. If you wish to make a Second Level Medical Appeal, you may do so by sending your appeal in writing to the following address:

**Horizon BCBSNJ Appeals Department
Mail Station PP-14E
PO Box 420
Newark NJ 07101-0420**

You may also initiate a Second Level Medical Appeal by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**.

To initiate a Second Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved.
- Member's identification number.
- Date(s) of service.
- Nature and reason behind your appeal.
- Remedy sought.
- Clinical documentation to support your appeal.

If a Second Level Medical Appeal is received, it is submitted to the Horizon BCBSNJ Appeals Committee. The Appeals Committee is made up of Horizon Medical Directors and staff, physicians from the community, and consumer advocates. A smaller subcommittee reviews Expedited Second Level Medical Appeals. The Appeals Coordinator will advise you of the date of your hearing. You have the option of attending the hearing in person or via telephone conference. You may also elect to have the Appeals Committee review and decide your Second Level Medical Appeal without your appearance.

Second Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard Second Level Medical Appeals are reviewed and decided within 15 calendar days of Horizon BCBSNJ's receipt.
- Second Level Expedited (urgent and emergent circumstances, as previously described) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon BCBSNJ's receipt of your First Level Medical Appeal request.

If you participate in the hearing, you will be notified of the Appeals Committee's decision verbally by telephone on the day of the hearing whenever possible. Written confirmation of the decision is sent to you and/or your physician or other authorized representative who pursued the Second Level Medical Appeal on your behalf. If you choose not to appear at the hearing you will be notified of the Appeals Committee's decisions in writing within five (5) business days of the decision. Horizon BCBSNJ's letter will include the specific reasons for the determination. If Horizon BCBSNJ's decision is not in your favor, you have the right to pursue an External Appeal through an Independent Review Organization (IRO).

Expedited Review of Second Level Medical Appeals

If the circumstances previously described in the "Expedited Review" section apply in your case (see page 55), you have the same right to an expedited review of your Second Level Medical Appeal.

EXTERNAL APPEAL RIGHTS

Standard External Appeals

If you are dissatisfied with the results of Horizon BCBSNJ's internal appeals process, and you wish to pursue an External Appeal with an Independent Review Organization (IRO), you must submit a written request within four (4) months from your receipt of Horizon BCBSNJ's final adverse benefit determination of your Appeal. To initiate a Standard External Appeal, you should submit a written request to the following address:

**Horizon BCBSNJ Appeals Department
Mail Station PP-14E
PO Box 420
Newark NJ 07101-0420**

Upon receipt of your written request, a preliminary review will be conducted by Horizon BCBSNJ and completed within five (5) business days to determine:

- Your eligibility under your group health plan at the time the service was requested or provided.

- That the adverse benefit determination does not relate to your failure to meet eligibility requirements under the terms of your group health plan (e.g. worker classification or similar).
- The internal appeals process has been exhausted (if required).
- You have provided all the information and forms required to process the external review.

After the completion of this preliminary review, written notification will be issued informing you of Horizon BCBSNJ's determination regarding the eligibility of your request for external review. If your request for an external review meets the eligibility requirements, your appeal will be assigned to an IRO by Horizon BCBSNJ. The IRO will notify you in writing of your request's eligibility and acceptance for external review. The IRO will review all of the information and documents received and will provide its written final external review decision to the claimant and Horizon BCBSNJ within 45 days after the IRO first received the request for the external review. Upon receipt of a final external review decision reversing an adverse benefit determination, Horizon BCBSNJ will provide coverage or payment for the claim(s) or service(s) involved. If the final external review decision upholds the adverse benefit determination, no further action is taken and the NJ DIRECT Medical Appeals Process is complete.

The Standard External Appeal rights described may be expedited in the following circumstances:

The initial adverse benefit determination involving medical judgment concerns a medical condition such that the completion of a Standard Internal Appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, and the member has filed a request for an Expedited Internal Appeal,

OR

The final adverse benefit determination (decision upon appeal) involving medical judgment concerns a medical condition such that the completion of a Standard External Appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, or if final adverse benefit determination involving medical judgment concerns an admission, availability of care, continued stay or a health care item or service for which the member received emergency services, but has not been discharged from the facility.

In instances of an expedited request, your request can be made by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**. For Expedited External Review requests, the final notice of the decision must be provided as expeditiously as the member's medical condition or circumstances require, but in no event shall exceed 72 hours from the IRO's receipt of the request for Expedited External Review.

NJ DIRECT ADMINISTRATIVE APPEAL PROCEDURE

The member or the member's authorized representative may appeal and request that Horizon BCBSNJ reconsider any claim or any portion(s) of a claim for which they believe benefits have been erroneously denied based on NJ DIRECT's limitations and/or exclusions. This appeal may be on an administrative nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Examples of Administrative Appeals include:

- Visits beyond the 30 visit chiropractic limit
- Benefits beyond the reasonable and customary allowance
- Routine Vision Services rendered out-of-network
- Benefits for a wig that exceed the \$500/24 month limit
- Hearing Aid for a 60 year old member

Adverse benefit determinations involving the application of plan benefits may usually be appealed up to three (3) times as outlined below:

- **First Level Administrative Appeal** – The First Level Administrative Appeal of an adverse benefit determination.
- **Second Level Administrative Appeal** – The Second Level Administrative Appeal of an adverse benefit determination available to you after completing a First Level Administrative Appeal.
- **Commission Appeal** – The Third Level Administrative Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Administrative Appeal. A Commission Appeal provides you the right to appeal to the State Health Benefits Commission/School Employees' Health Benefits Commission.

An overview of the administrative appeal process is provided below. An NJ DIRECT Administrative Appeals Procedure brochure will be provided with every administrative adverse benefit determination. The brochure provides a comprehensive description of the procedures.

First Level Administrative Appeal

The member may request an administrative appeal by calling **1-800-414-SHBP (7427)** or submitting a written appeal to:

**Horizon Blue Cross Blue Shield of New Jersey
NJ DIRECT Appeals
PO Box 820
Newark New Jersey 07101**

The member has one (1) year following your receipt of the initial adverse benefit determination letter to request an Administrative Appeal.

The First Level Administrative Appeal should include the following information:

- Name and address of the patient and the NJ DIRECT member;
- Member's NJ DIRECT identification number;

- Date(s) of service(s);
- Provider's name and identification number;
- Physician's name and identification number;
- The reason you think the claim/service should be reconsidered;
- All documentation supporting your appeal.

You will receive a written response to your First Level Administrative Appeal within 30 days. If you are not satisfied with this written determination, a Second Level Administrative Appeal may be requested.

Second Level Administrative Appeal

The member may request a Second Level Administrative Appeal within one (1) year following receipt of the initial adverse benefit determination letter by calling **1-800-414-SHBP (7427)**, or by writing to the address noted earlier. The member may also send an appeal via fax to **1-973-274-4599**.

During the Second Level Administrative Appeal, Horizon BCBSNJ will review any additional evidence the member wished to supply in support of the appeal. The member will receive a written determination of the final decision within 30 days. This will complete the Horizon BCBSNJ appeal options.

Commission Appeal

Once all appeal options have been exhausted through Horizon BCBSNJ, the member may appeal to the State Health Benefits Commission/School Employees' Health Benefits Commission (Commission). If dissatisfied with a final Horizon BCBSNJ decision on an administrative appeal, you have one (1) year following receipt of the initial adverse benefit determination letter to request a Commission Appeal. Only the member or the member's legal representative may appeal, in writing, to the Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to:

**Appeals Coordinator
State Health Benefits Commission/
School Employees' Health Benefits Commission
PO Box 299
Trenton NJ 08625-0299**

The member will be advised by the Commission how to arrange a hearing date, the date of the hearing and the option to attend and appear before the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request in writing to the Commission, within 45 days, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of

Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify or reject.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. The member will be responsible for any expenses involved in gathering evidence or material that will support the grounds for appeal. The member will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If an attorney or expert medical testimony is required, the member will be responsible for any fees or costs incurred.

If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

PRESCRIPTION DRUG BENEFITS

The State Health Benefits Commission and School Employees' Health Benefits Commission require that all covered employees and retirees have access to prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, Preferred Drug Step Therapy (PDST)* and the Specialty Pharmacy Program are employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions also apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.). Certain drugs that require administration in a physician's office may be covered through your medical plan.

*PDST does not apply to certain State employees and their dependents.

EMPLOYEE PRESCRIPTION DRUG COVERAGE

State Employees

State employees enrolled in NJ DIRECT medical plans have access to a prescription drug plan. Plan benefits are available through retail pharmacies, by mail order through Express Scripts, and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy.

The plans feature a three tier copayment design, except for high deductible health plans. Retail pharmacy services require a copayment for up to a 30-day supply of prescription drugs. Mail order participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. Specialty pharmacy services are only provided via mail through Accredo. If your doctor prescribes a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

If enrolled in NJ DIRECT HD1500 or NJ DIRECT HD4000, prescription drugs are subject to a deductible and coinsurance.

See the SHBP/SEHBP [Prescription Drug Plans Member Handbook](#) for additional information on prescription drug benefits and limitations.

The amount that State employees and their eligible dependents pay for prescription drugs is determined by the medical plan the employee selects.

Note: In the past, regardless of which medical plan you were enrolled, the Employee Prescription Drug Plan copayments were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

The State Health Benefit Plan Design Committee establishes the copayment amounts on an annual basis. In Plan Year 2013 a State employee or dependent will pay the following copayments amounts.

Prescription Drug Plan Copayments – State Employees

Member Copayment up to 30-day supply retail or up to 90-day supply by mail order	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT HD1500 NJ DIRECT HD4000
Retail Generic	\$3.00	\$7.00	\$3.00	Subject to deductible and coinsurance
Retail Brand without generic equivalent	\$10.00	\$16.00	\$18.00	Subject to deductible and coinsurance
Retail Brand with generic equivalent	\$25.00	\$35.00	\$46.00	Subject to deductible and coinsurance
Mail Order Generic	\$5.00	\$18.00	\$5.00	Subject to deductible and coinsurance
Mail Order Brand without generic equivalent	\$15.00	\$40.00	\$36.00	Subject to deductible and coinsurance
Mail Order Brand with generic equivalent	\$40.00	\$88.00	\$92.00	Subject to deductible and coinsurance
There is no coordination of benefits between two freestanding prescription drug plans				

Note: The following **preventive medications** are covered with a doctor's prescription with a zero dollar copayment for certain members meeting specific criteria (see the [Prescription Drug Plans Member Handbook](#) for specific limits related to age, gender, and medical condition): Aspirin, Fluoride, Folic Acid, Iron supplements, and certain drugs that assist with Smoking Cessation.

Local Government and Local Education Employees

The amount that local government/education employees and their eligible dependents pay for prescription drugs is determined by the prescription drug plan option provided by the employer and the medical plan the employee selects. Local government and local education employers may elect one of the following three options to provide prescription drug benefits to their employees: The SHBP/SEHBP Prescription Drug Plans, NJ DIRECT Employee Prescription Drug Plan, or a private (non-SHBP/SEHBP) prescription drug plan.

- 1. The SHBP/SEHBP Prescription Drug Plans:** Benefits are available through retail pharmacies, by mail order through Express Scripts, and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy. The plans feature a three tier copayment design, except for the high deductible health plans. Retail pharmacy services require a copayment for up to a 30-day supply of prescription drugs. Mail order participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. Specialty pharmacy services are only provided via mail through Accredo. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

See the SHBP/SEHBP [Prescription Drug Plans Member Handbook](#) for additional information on prescription drug benefits and limitations.

The State Health Benefit and School Employees' Health Benefit Plan Design Committees establish the copayment amounts on an annual basis.

Note: In the past, regardless of which medical plan you were enrolled, the Employee Prescription Drug Plan copayments were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

In Plan Year 2013 a local government/education employee or dependent will pay the following copayments amounts:

Prescription Drug Plan Copayments Local Government and Local Education Employees

Member Copayment up to 30-day supply retail or up to 90-day supply by mail order	NJ DIRECT10 NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT HD1500 NJ DIRECT HD4000
Retail Generic	\$3.00	\$7.00	\$3.00	Subject to deductible and coinsurance
Retail Preferred Brand	\$10.00	\$16.00	\$18.00	Subject to deductible and coinsurance
Retail Non-preferred Brand	\$10.00	\$35.00	\$46.00	Subject to deductible and coinsurance
Mail Order Generic	\$5.00	\$18.00	\$5.00	Subject to deductible and coinsurance
Mail Order Preferred Brand	\$15.00	\$40.00	\$36.00	Subject to deductible and coinsurance
Mail Order Non-preferred Brand	\$15.00	\$88.00	\$92.00	Subject to deductible and coinsurance
There is no coordination of benefits between two freestanding prescription drug plans				

Note: The following **preventive medications** are covered with a doctor's prescription with a zero dollar copayment for certain members meeting specific criteria (see the [Prescription Drug Plans Member Handbook](#) for specific limits related to age, gender, and medical condition): Aspirin, Fluoride, Folic Acid, Iron supplements, and certain drugs that assist with Smoking Cessation.

2. **The NJ DIRECT Employee Prescription Drug Plan:** This option is available to local government and local education employees enrolled in NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, or NJ DIRECT2030, when the local public employer **does not** provide either the SHBP/SEHBP Prescription Drug Plan or a private prescription drug plan.

For members enrolled in the NJ DIRECT Employee Prescription Drug Plan, prescription drugs are included in the medical plan and are subject to coinsurance in-network and the deductible and coinsurance out-of-network. The member pays the applicable deductible and coinsurance until the out-of-pocket maximum is met. Express Scripts administers all aspects of the NJ DIRECT Employee Prescription Drug

Plan and exchanges claim transactions with Horizon BCBSNJ for application to the combined medical and prescription deductible and out-of-pocket maximums.

NJ DIRECT Employee Prescription Drug Plan Coinsurance Local Government and Local Education Employees

NJ DIRECT Employee Prescription Drug Plan	NJ DIRECT10	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030
Participating Retail or Mail Order Pharmacy	90% coverage	90% coverage	90% coverage	85% coverage
Non-participating Pharmacy	80% coverage after deductible	70% coverage after deductible	70% coverage after deductible	70% coverage after deductible

- Prescription drugs are covered at the in-network benefit level when obtained through a participating retail or mail pharmacy. Members are responsible for paying the 10 percent or 15 percent coinsurance to the pharmacy at the point of sale until the in-network out-of-pocket maximum is reached. The in-network out-of-pocket maximum is \$400 single and \$1,000 family for NJ DIRECT10, NJ DIRECT15, and NJ DIRECT1525 members; and \$800 single and \$2000 family for NJ DIRECT2030 members.
- Prescription drugs are reimbursed at the out-of-network level when obtained through a non-participating pharmacy until the out-of-network out-of-pocket maximum is reached. The out-of-network out-of-pocket maximum is \$2,000 single and \$5,000 family for NJ DIRECT10, NJ DIRECT15, and NJ DIRECT1525 members; and \$5,000 single and \$12,500 family for NJ DIRECT2030 members. Members are responsible for paying the full cost of the prescription medications obtained from a non-participating pharmacy and submitting the claim to Express Scripts for processing.
- Prescription drugs are available by mail order through Express Scripts, or online at: www.medco.com/statenj Specialty pharmacy services for self administered prescription medications also apply and are provided through Accredo, Express Scripts' specialty pharmacy.

If enrolled in NJ DIRECT HD1500 or NJ DIRECT HD4000*, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full discounted cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met. Express Scripts administers all aspects of the prescription drug coverage for NJ DIRECT HD1500 and NJ DIRECT HD4000 and exchanges claim transactions with Horizon BCBSNJ for application to the combined deductible and out of pocket maximum.

See the SHBP/SEHBP [Prescription Drug Plans Member Handbook](#) for additional information on prescription drug benefits and limitations.

*Local education employees are not eligible for any of the HD4000 plans.

3. **A private (non-SHBP/SEHBP) prescription drug plan** that is at least equal to the Employee Prescription Drug Plan.

RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in a SHBP or SEHBP medical plan have access to the **Retiree Prescription Drug Plan**. Plan benefits are available through participating retail pharmacies, by mail order through Express Scripts, and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy.

The plan features a three-tier copayment design except for high deductible health plans. Retail pharmacy services require a copayment for up to a 30-day supply of prescription drugs. Mail order participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. Specialty pharmacy services are only provided via mail through Accredo. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in the Express Scripts Medicare Prescription Drug Plan, a Medicare Part D plan.

Important: If you decide not to be enrolled in the Express Scripts Medicare Prescription Drug Plan, you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Express Scripts Medicare Prescription Drug Plan, you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a [Retired Change of Status Application](#) waiving your prescription drug coverage.

RETIREE PRESCRIPTION DRUG COPAYMENTS

The amount that retired members and their eligible dependents pay for prescription drugs is determined by the medical plan the retiree selects.

Effective January 1, 2013, copayments for retiree prescription drug coverage are as follows.

State Retirees and Local Government Retirees

- If enrolled in NJ DIRECT10 or NJ DIRECT15, the copayment at a retail pharmacy for up to a 30-day supply is \$11 for *generic* drugs; \$23 for *preferred* brand name drugs; and \$46 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$11 for *generic* drugs; \$34 for *preferred* brand name drugs; and \$57 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,355 per person.
- If enrolled in NJ DIRECT1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for *preferred* brand name drugs; and \$35 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$40 for *preferred* brand name drugs; and \$88 for *non-preferred* brand name drugs. There is no out-of-pocket maximum.

- If enrolled in NJ DIRECT2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$46 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$36 for *preferred* brand name drugs; and \$92 for *non-preferred* brand name drugs. There is no out-of-pocket maximum.
- If enrolled in the High Deductible Health Plan, NJ DIRECT 4000*, the prescription drugs are included *in the* medical plan and *are subject* to a deductible and coinsurance. *This means* that the member pays the full cost of the medications until the deductible is reached. Once the deductible *is reached*, the member *pays the* applicable coinsurance until *the out-of-pocket* maximum is met.

*Medicare eligible retirees **cannot** enroll a High Deductible Health Plan.

Local Education Retirees

- If enrolled in NJ DIRECT10 or NJ DIRECT15, the copayment at a retail pharmacy for up to a 30-day supply is \$10 for *generic* drugs; \$20 for *preferred* brand name drugs; and \$40 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$30 for *preferred* brand name drugs; and \$50 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.
- If enrolled in NJ DIRECT1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for *preferred* brand name drugs; and \$35 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$40 for *preferred* brand name drugs; and \$88 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.
- If enrolled in NJ DIRECT2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$46 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$36 for *preferred* brand name drugs; and \$92 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.
- If enrolled in the High Deductible Health Plan, NJ DIRECT 4000*, the prescription drugs are included in the medical plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

*Medicare eligible retirees **cannot** enroll a High Deductible Health Plan.

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods (see "Duration of COBRA Coverage" on page 68), and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription drug, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurred within 60 days of the COBRA event.

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll, if eligible, in any medical, dental, or prescription drug coverage during the Annual Open Enrollment Period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the Annual Open Enrollment Period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission or School Employees' Health Benefits Commission make changes to any benefit plan available to active employees and/or retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents who would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member/retiree.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of a civil union or domestic partnership (makes spouse/ partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.

- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

Note: Employees who at retirement are eligible to enroll in SHBP or SEHBP Retired Group coverage cannot enroll for health benefits coverage under COBRA.

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence.**

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Proof of Social Security Administration determination must be submitted to the Health Benefits Bureau of the Division of Pensions and Benefits within 60 days of the award or within 60 days of COBRA enrollment. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or domestic partnership**, or a child becomes ineligible for continued group coverage because of **attaining age 26, or** because you **elected Medicare as your primary coverage.**

If a second qualifying event — such as a divorce — occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you and your dependents of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;

- Notify the Health Benefits Bureau of the Division of Pensions and Benefits within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- You or your eligible dependents must notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or domestic partnership, or your death has occurred or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- File a *COBRA Application* (obtained from your employer or the Health Benefits Bureau) within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a “qualified beneficiary” under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP or SEHBP;
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

APPENDIX I

SPECIAL PLAN PROVISIONS UNDER NJ DIRECT

WORK-RELATED INJURY OR DISEASE

Work-related injuries or disease are not covered under NJ DIRECT. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not your injuries are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work related tests, examinations or immunizations of any kind required by your work except employer mandated examinations that are a prerequisite for participation in an employer mandated physical fitness test required as a condition of continuing employment.
- Work related injuries will not be eligible for benefits under your medical plan before or after your Worker's Compensation carrier has settled or closed your case.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and NJ DIRECT, you may be subject to prosecution for insurance fraud.

MEDICAL PLAN EXTENSION OF BENEFITS

If you or a dependent are disabled with a condition or illness at the time of your termination from the SHBP or SEHBP, you may qualify for an extension of benefits for this specific condition or illness. You do not qualify for an extension of benefits if you currently have or are eligible for any other type of medical coverage including but not limited to Medicare. If you feel that you may qualify for an extension of benefits please contact Horizon BCBSNJ at 1-800-414-SHBP (7427) for assistance.

If the extension applies, it is only for eligible expenses relating to the disabling condition or illness. An extension under NJ DIRECT will be for the time you or your dependent remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which your coverage ends.

TERMINATION FOR CAUSE

If any of the following conditions exist, you may receive written notice that you will no longer be covered under NJ DIRECT.

- If, after reasonable efforts, NJ DIRECT and/or participating providers are unable to establish and maintain a satisfactory, provider/patient relationship with you or you repeatedly act in a manner which is verbally or physically abusive.
- If you permit any person who is not authorized to use the identification card(s) issued to you. You may be liable for the cost of any claims paid for services for an ineligible individual.
- If you willfully furnish incorrect or incomplete information in a statement made for the purpose of effecting coverage.
- If you abuse the system, including, but not limited to theft, damage to a participating providers' property, or forgery of prescriptions.

Any action by NJ DIRECT under these provisions is subject to review in accordance with the established appeals procedures. If an appeal is denied and the decision upheld, this action is subject to appeal to either the State Health Benefits Commission or School Employees' Health Benefits Commission. No benefits, other than for emergencies, will be provided to the member and to any family members under the coverage as of 31 days after such written notice is given by NJ DIRECT.

If the State Health Benefits Commission or School Employees' Health Benefits Commission overrules the decision to terminate, benefits will be restored.

APPENDIX II

SUMMARY SCHEDULES OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP or SEHBP and Horizon BCBSNJ govern this plan. The following schedules of benefits are summary descriptions of plan benefits and are not a complete listing. They do not describe all the limitations or conditions associated with the coverage as described in other sections of this handbook. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in these schedules. Horizon BCBSNJ will administer the coverage listed in the Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations, and exclusions stated within this handbook.

Please note: The fact that a doctor may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and/or diagnosis of an illness or injury or make it a covered medical expense. Certain services are subject to precertification.

NJ DIRECT ELIGIBLE SERVICES AND SUPPLIES

In-Network: The following copayments apply to the services unless otherwise indicated;

- NJ DIRECT10 \$10
- NJ DIRECT15 \$15
- NJ DIRECT1525 \$15 primary care
 \$25 specialty care
- NJ DIRECT2030 \$20 primary care for adults and children and specialty care for children to 26
 \$30 specialty care for adults

Where indicated under “Out-of-Network” services in the following pages, the reimbursement is 80 percent under NJ DIRECT10 and 70 percent under NJ DIRECT15, NJ DIRECT1525, and NJ DIRECT2030 of the reasonable and customary or out-of-network allowance.

NJ DIRECT COVERED SERVICES

Acupuncture for Pain Management Only

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Alcohol or Substance Abuse Treatment (Inpatient)

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** coverage, subject to precertification

A separate \$200 deductible per inpatient hospital stay applies for the SHBP NJ DIRECT10, SHBP NJ DIRECT15, and SHBP/SEHBP NJ DIRECT1525; a \$500 deductible per stay applies for SHBP/SEHBP NJ DIRECT2030. The standard deductible applies for SEHBP NJ DIRECT10 and NJ DIRECT15.

Alcohol or Substance Abuse Treatment (Outpatient)

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Allergy Testing

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Ambulance Services

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Ambulatory Surgery

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Anesthesia

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Biofeedback for General Conditions

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Biofeedback for Non-Biologically-Based Mental Illnesses (outpatient)

In-Network **90 percent** of reasonable and customary allowance
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Biologically-Based Mental or Nervous Condition Treatment (Inpatient)

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** coverage, subject to precertification

A separate \$200 deductible per inpatient hospital stay applies for the SHBP NJ DIRECT10, SHBP NJ DIRECT15, and SHBP/SEHBP NJ DIRECT1525; a \$500 deductible per stay applies for SHBP/SEHBP NJ DIRECT2030. The standard deductible applies for SEHBP NJ DIRECT10 and NJ DIRECT15.

Biologically-Based Mental or Nervous Condition Treatment (Outpatient)

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Chiropractic Services (No Referral Required)

In-Network and Out-of-Network is one combined 30 visit maximum.

In-Network **100 percent** coverage for maximum of 30 visits per calendar year

Out-of-Network **70/80 percent** of the reasonable and customary allowance
for maximum of 30 visits per calendar year

Diagnostic Laboratory

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Diagnostic X-Ray

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Dialysis Center Charges

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Durable Medical Equipment

In-Network **90 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Emergency Room

In-Network **100 percent** coverage, after copayment*
(copayment is \$25 for NJ DIRECT10, \$50 for NJ DIRECT15,
\$75 for NJ DIRECT1525, and \$125 for NJ DIRECT2030)

Out-of-Network** **100 percent** coverage, after copayment*
(copayment is \$25 for NJ DIRECT10, \$50 for NJ DIRECT15,
\$75 for NJ DIRECT1525, and \$125 for NJ DIRECT2030)

**For both In-Network and Out-of-Network services the \$50/\$25 copayment is waived if admitted.*

***Out-of-Network benefit applies if non-emergent.*

Hospital Charges

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** coverage, subject to precertification

A separate \$200 deductible per inpatient hospital stay applies for the SHBP NJ DIRECT10, SHBP NJ DIRECT15, and SHBP/SEHBP NJ DIRECT1525; a \$500 deductible per stay applies for SHBP/SEHBP NJ DIRECT2030. The standard deductible applies for SEHBP NJ DIRECT10 and NJ DIRECT15.

Home Health Care

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Hospice Care

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

A separate \$200 deductible per inpatient hospital stay applies for the SHBP NJ DIRECT10, SHBP NJ DIRECT15, and SHBP/SEHBP NJ DIRECT1525; a \$500 deductible per stay applies for SHBP/SEHBP NJ DIRECT2030. The standard deductible applies for SEHBP NJ DIRECT10 and NJ DIRECT15.

Inpatient Hospice Care

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance.

A separate \$200 deductible per inpatient hospital stay applies for the SHBP NJ DIRECT10, SHBP NJ DIRECT15, and SHBP/SEHBP NJ DIRECT1525; a \$500 deductible per stay applies for SHBP/SEHBP NJ DIRECT2030. The standard deductible applies for SEHBP NJ DIRECT10 and NJ DIRECT15.

Inherited Metabolic Disease Medical Foods

In-Network **90 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Inpatient Physician Services

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Maternity/Obstetrical Care

In-Network **100 percent** coverage after a copayment for initial visit

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Non-Biologically-Based Mental or Nervous Condition Treatment (Inpatient)

In-Network **100 percent** up to 25 days per calendar year;
balance at **90 percent**

Out-of-Network **50 percent** to a maximum of 50 days per calendar year

Non-Biologically-Based Mental or Nervous Condition Treatment (Outpatient)

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Non-Biologically-Based Mental or Nervous Conditions Inpatient Medical Visits

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Nutritional Counseling

In-Network **100 percent** coverage (3 visits per year)
Out-of-Network **No coverage**

Physical Therapy and Occupational Therapy

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Pre-Admission Testing

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Preventive Care

Under the Patient Protection and Affordable Care Act some preventive care services are covered with **no** out-of-pocket cost (no copayment), when you receive the services from an in-network health care professional and the sole reason for the visit is to receive the preventive care services. If your health care professional provides a preventive service as part of an office visit, you may be responsible for cost sharing for the office visit if the preventive service is not the primary purpose of your visit or if the provider bills you for the office visit separately from the preventive care.

- **Annual Routine Gynecological Care and Examinations (limited to one per year)**
In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance
- **Annual Wellness Visit (Preventive Care)**
In-Network **100 percent** coverage (no copayment)
Out-of-Network **No coverage**
- **Immunizations**
In-Network **100 percent** coverage (no copayment)
Out-of-Network **No coverage**

- **Mammography**
In-Network **100 percent** coverage (no copayment)
Out-of-Network Coverage for one routine mammography is eligible at the Out-of-Network level and is covered at **70/80 percent** of the reasonable and customary allowance
- **PAP Smears**
In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance for an annual routine pap smear
- **Prostate Cancer Screening**
In-Network **100 percent** coverage
Out-of-Network **No coverage**
- **Well-Child Care**
In-Network **100 percent** coverage (no copayment)
Out-of-Network **No coverage**
- **Well-Child Immunizations**
In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance, under 12 months of age only

Private Duty Nursing (Outpatient)

- In-Network** **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Second Surgical Opinion Charges (Voluntary)

- In-Network** **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Skilled Nursing Facility Charges

Combined In-Network and Out-of-Network Maximum of 120 Days

- In-Network** **100 percent** coverage for up to 120 days per calendar year (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance up to 60 days per calendar year

A separate \$200 deductible per inpatient hospital stay applies for the SHBP NJ DIRECT10, SHBP NJ DIRECT15, and SHBP/SEHBP NJ DIRECT1525; a \$500 deductible per stay applies for SHBP/SEHBP NJ DIRECT2030. The standard deductible applies for SEHBP NJ DIRECT10 and NJ DIRECT15.

Specialist Services

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Specialized Non-Standard Infant Formula

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Speech Therapy

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Surgical Services

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Transplant Benefits

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Vision Examination (routine exam limited to one per year)

In-Network **100 percent** coverage
Out-of-Network **No coverage**

NJ DIRECT HDHP ELIGIBLE SERVICES AND SUPPLIES

In-Network and Out-of-Network: The annual deductible and coinsurance apply to all service unless otherwise indicated. Where indicated in-network reimbursement is 80 percent of the plan allowance and out-of-network reimbursement is 60 percent of the reasonable and customary allowance for NJ DIRECT High Deductible Health Plans.

NJ DIRECT HDHP COVERED SERVICES

Acupuncture for Pain Management Only

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Alcohol or Substance Abuse Treatment (Inpatient)

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Alcohol or Substance Abuse Treatment (Outpatient)

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Allergy Testing

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Ambulance Services

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Ambulatory Surgery

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Anesthesia

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Biofeedback for General Conditions

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Biofeedback for Non-Biologically-Based Mental Illnesses (Outpatient)

In-Network..... **80 percent** of the plan allowance
Out-of-Network.....**60 percent** for the reasonable and customary allowance

Biologically-Based Mental or Nervous Condition Treatment

In-Network..... *Inpatient:* **80 percent** of the plan allowance
Outpatient: **80 percent** of the plan allowance
Out-of-Network*Inpatient:* **60 percent** of the reasonable and customary allowance
Outpatient: **60 percent** of the reasonable and customary allowance

Chiropractic Services (No Referral Required)

In-Network and Out-of-Network is one combined 30 visit maximum.

In-Network **80 percent of the plan allowance** for maximum
of 30 visits per calendar year
Out-of-Network **60 percent** of the reasonable and customary allowance
for maximum of 30 visits per calendar year

Diagnostic Laboratory

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Diagnostic X-Ray

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Dialysis Center Charges

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Durable Medical Equipment

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Emergency Room

In-Network **80 percent** of the plan allowance
Out-of-Network* **80 percent** of the plan allowance

**Out-of-Network benefit applies if non-emergent.*

Hospital Charges

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** coverage, subject to precertification

Home Health Care

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Hospice Care

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Inpatient Hospice Care

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Inherited Metabolic Disease Medical Foods

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Inpatient Physician Services

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Maternity/Obstetrical Care

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Non-Biologically-Based Mental or Nervous Condition Treatment

In-Network..... *Inpatient:* **80 percent** of the plan allowance
Outpatient: **80 percent** of the plan allowance
Out-of-Network *Inpatient:* **60 percent** of the reasonable and customary allowance for 50 days per calendar year
Outpatient: **60 percent** of the reasonable and customary allowance

Non-Biologically-Based Mental or Nervous Conditions Inpatient Medical Visits

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Nutritional Counseling

In-Network **80 percent** of the plan allowance (3 visits per year)
Out-of-Network **No coverage**

Physical Therapy and Occupational Therapy

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Pre-Admission Testing

In-Network **80 percent** of the plan allowance
Out-of-Network **60 percent** of the reasonable and customary allowance

Preventive Care (The in-network preventive services listed below are **not** subject to the annual deductible.)

- **Annual Routine Gynecological Care and Examinations (limited to one per year)**
In-Network **100 percent** coverage
Out-of-Network **60 percent** of the reasonable and customary allowance
- **Annual Routine Physicals and Immunizations**
In-Network **100 percent** coverage
Out-of-Network **No coverage**

- **Routine Mammography**

In-Network **100 percent** coverage

Out-of-Network Coverage for one routine mammography is eligible at the Out-of-Network level and is covered at **60 percent** of the reasonable and customary allowance

- **Routine Colorectal Cancer Screening**

In-Network 100 percent coverage

Out-of-Network No coverage

- **Routine PAP Smears**

In-Network 100 percent coverage

Out-of-Network **60 percent** of the reasonable and customary allowance for an annual routine pap smear

- **Routine Prostate Cancer Screening**

In-Network 100 percent coverage

Out-of-Network No coverage

- **Well-Child Care**

In-Network 100 percent coverage

Out-of-Network No coverage

- **Well-Child Immunizations**

In-Network 100 percent coverage

Out-of-Network **60 percent** of the reasonable and customary allowance, under 12 months of age only

Private Duty Nursing (Outpatient)

In-Network **80 percent** of the plan allowance

Out-of-Network60 percent of the reasonable and customary allowance

Second Surgical Opinion Charges (Voluntary)

In-Network **80 percent** of the plan allowance

Out-of-Network60 percent of the reasonable and customary allowance

Skilled Nursing Facility Charges

Combined In-Network and Out-of-Network Maximum of 120 Days

In-Network **80 percent** of the plan allowance
for up to 120 days per calendar year

Out-of-Network **60 percent** of the reasonable and customary allowance up to 60 days per calendar year

Specialist Services

In-Network **80 percent** coverage
Out-of-Network **60 percent** of the reasonable and customary allowance

Specialist Non-Standard Infant Formula

In-Network **80 percent** coverage
Out-of-Network **60 percent** of the reasonable and customary allowance

Speech Therapy

In-Network **80 percent** coverage
Out-of-Network **60 percent** of the reasonable and customary allowance

Surgical Services

In-Network **80 percent** coverage
Out-of-Network **60 percent** of the reasonable and customary allowance

Transplant Benefits

In-Network **80 percent** coverage
Out-of-Network **60 percent** of the reasonable and customary allowance

Vision Examination (routine exam limited to one per year)

In-Network **100 percent** coverage
Out-of-Network **No coverage**

APPENDIX III

GLOSSARY

Accidental Injury — Physical harms or damage done to a person as a result of a chance or unexpected occurrence.

Active Group Member (subscriber) — An employee who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage for him or herself and, if applicable, any eligible dependents. Also includes eligible employees or dependents who continue coverage as a subscriber in the COBRA program.

Activities of Daily Living — Day-to-day activities, such as dressing, feeding, toileting, transferring, ambulating, meal preparation, and laundry functions.

Allowable Expense — The allowance for charges for services rendered or supplies furnished by a health care provider that would qualify as a covered expense.

Ambulatory Surgical Center — An accredited ambulatory care facility licensed as such by the state in which it operates to provide same-day surgical services.

Appeal — A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the Health Benefits Commission may only be filed by a member or the member's legal representative.

Benefit Period — The twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Biologically-Based Mental Illness — Diagnosed conditions including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Calendar Year — A year starting January 1 and ending on December 31.

Case Manager — A person or entity designated by the plan to manage, assess, coordinate, direct, and authorize the appropriate level of health care treatment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or [Fact Sheet #75](#), *Civil Unions*, for details).

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coinsurance — The portion of an eligible charge which is the member's financial responsibility for out-of-network services.

Consumer Driven Health Plan — A type of health coverage that offers the protection of a high deductible health plan along with a tax advantage account (Health Savings Account for NJ DIRECT HD1500 and NJ DIRECT HD4000). The funds in the subscriber's account can be used to pay for qualified medical expenses or be reserved for future medical needs at the subscriber's discretion.

Coordination of Benefits — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the actual expense, and (3) the plan does not pay more than it would if no other insurance existed.

Copayment — The fee charged to a member or patient to be paid directly to the participating provider or network specialist at the time treatment is rendered for certain covered services.

Cosmetic Services — Services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Covered Person (member) — An employee, retiree, or COBRA participant or a dependent of an employee, retiree, or COBRA participant who is enrolled.

Coverage — The plan design of payment for medical expenses under the program.

Custodial Care — Services that do not require the skill level of a nurse to perform. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Custodial care services are not eligible for coverage under the plan, including those that are considered to be medically needed.

Dependent — A member's spouse, civil union partner, or same-sex domestic partner (as defined by Chapter 246, P.L. 2003); and unmarried child(ren) under the age of 23 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage may be continued subject to approval.

Deductible — The portion of the first eligible charges submitted for payment in each calendar year that the out-of-network portion of NJ DIRECT requires the member or covered dependent to pay.

Detoxification Facility — A health care facility licensed by the state as a detoxification facility for the treatment of alcoholism and/or substance abuse.

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic

partner coverage may be subject to federal tax (see your employer or [Fact Sheet #71, Benefits Under the Domestic Partnership Act](#), for details).

Durable Medical Equipment — Equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Eligible Services and Supplies — These are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined below:

- Medically needed at the appropriate level of care for the medical condition.
- Listed in covered services and supplies.
- Ordered by a doctor (as defined by NJ DIRECT) for treatment of illness or injury.
- Not specifically excluded (listed in the “Charges Not Covered by NJ DIRECT” section on page 43).
- Provided while you or your eligible family members were covered by NJ DIRECT.

Emergency — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Employer — The State, or a local government public employer that participates in the State Health Benefits Program, or a local education public employer that participates in the School Employees’ Health Benefits Program.

Facility Charges — Charges from an eligible medical institution such as a hospital, residential treatment center, detoxification center, ambulatory or separate surgical center, dialysis center, or a skilled nursing center.

Family or Medical Leave of Absence — A period of time of pre-determined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an

approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be active for purposes of eligibility for covered services and supplies under your group's program.

Full Medicare Coverage — Enrollment in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the federal Medicare Program. ***State law requires that anyone who is enrolled in the Retired Group and is eligible for Medicare must enroll in both Parts A and B of the Medicare Program in order to be covered in the State Health Benefits Program or School Employees' Health Benefits Program.***

Gestational Carrier — A woman who has become pregnant with an embryo or embryos that are not part of her genetic or biologic entity, and who intends to give the child to the biological parents after birth.

Government Hospital — A hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county, or city hospital.

Health Savings Account (HSA) — a tax-advantaged personal account that is coupled with a High Deductible Health Plan. Members can use the HSA to pay for current and future qualifying medical expenses. HSAs were introduced as a part of the Medicare Modernization Act of 2003.

High Deductible Health Plan — A qualified High Deductible Health Plan (HDHP) is a health plan with a minimum individual deductible and minimum family coverage deductible. The U.S. Treasury defines the requirements for a qualified HDHP. Once an employee reaches the defined limits the insurance plan will cover benefits at the percentage specified in the plan. Almost all services are applied to the deductible including prescriptions. The law allows an exception for preventive care such as annual physical exams and immunizations which can be covered at 100 percent without being applied to the high deductible.

Home Health Care Agency — A provider which mainly provides skilled nursing care and therapeutic services for an ill or injured person in the home under a home health care program designed to eliminate hospital stays. To be eligible for reimbursement it must be licensed by the state in which it operates, or be certified to participate in Medicare as a home health care agency.

Horizon MyWay Visa/Debit Card — Horizon MyWay HSA members are issued a Visa /Debit Card. This card can be used to directly pay for qualified medical expenses from the HSA if sufficient funds are available.

Hospice — A provider that renders a health care program which provides an integrated set of services designed to provide comfort, pain relief and supportive care for terminally ill or terminally injured people under a hospice care program.

Hospital — An approved institution that meets the tests of 1, 2, 3, 4, or 5, listed below:

1. It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.
2. It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.
3. It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.

4. It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:
 - A licensed hospital; or
 - A licensed detoxification facility; or
 - A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals. (Educational services provided while at an approved treatment facility is not eligible).
5. It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets all of the following tests:
 - It is equipped and operated mainly to provide an alternative method of childbirth.
 - It is under the direction of a doctor.
 - It allows only doctors to perform surgery.
 - It requires an exam by an obstetrician at least once before delivery.
 - It offers prenatal and postpartum care.
 - It has at least two birthing rooms.
 - It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator.
 - It has the services of registered graduate nurses.
 - It does not allow patients to stay more than 24 hours.
 - It has written agreements with one or more hospitals in the area that meet the tests listed above in (1) or (2) and will immediately accept patients who develop complications or require post-delivery confinement.
 - It provides for periodic review by an outside agency.
 - It maintains proper medical records for each patient.

“Hospital” does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides home-like or custodial care.

Illness — Any disorder of the body or mind.

Injury — Damage to the body.

Local Employee — For purposes of health benefits coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who

receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Maintenance Care — Care that does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible for reimbursement. Maintenance care services, even those that are considered to be medically needed, are not eligible for coverage under NJ DIRECT.

Medical Need and Appropriate Level of Care — A service or supply that NJ DIRECT determines meets **each** of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.
- That it is the most appropriate level of service or supply considering the potential benefits and harm to the patient.
- It is known to be effective in improving health outcomes (for new interventions, effectiveness is determined by scientific evidence; then, if necessary, by professional standards; then, if necessary, by expert opinion).

Medicare — The federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A Retired Group member and/or spouse who are eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in SHBP or SEHBP Retired Group coverage.

Member — An employee, retiree, COBRA enrollee or dependent who is enrolled under NJ DIRECT.

Mental or Nervous Condition — A condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions include, but are not limited to, psychoses, neurotic

and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Mental or nervous condition does not include substance abuse or alcoholism.

Morbid Obesity — A body mass index (BMI) greater than 40kg/m², or a BMI greater than 35kg/m² with associated life-threatening or disabling co-morbidities including, but not limited to, coronary heart disease, diabetes, hypertension, or obstructive sleep apnea.

Mouth Condition — A condition involving one or more teeth, the tissue or structure around them, or the alveolar process of the gums.

Off-Label Use — A drug not approved by the FDA for treatment of the condition in question or prescribed at a different dosage than the approved dosage.

Out-of-Network Benefits — Benefits provided by NJ DIRECT when members do not use network providers for their medical treatment or do not follow the managed care guidelines.

Out-of-Network Plan Allowance — An out-of-network plan allowance is used on the benefit determination when valid reasonable and customary data is not available. The out-of-network allowance is used to establish a reasonable level of reimbursement. One example is the allowance for Ambulatory Surgery Centers (ASC's). The out-of-network allowance used for ASC's is based on a percentage of the Centers for Medicaid Services (CMS) allowance.

Participating Provider — A doctor or hospital which has a written agreement NJ DIRECT to provide care.

Precertification — A process by which the eligibility and medical appropriateness of services or supplies is determined before services are rendered.

Primary Health Plan — A plan which pays benefits for a member's covered charge first, ignoring what the member's secondary plan pays. A secondary health plan then pays the remaining unpaid expenses in accordance with the provisions of the member's secondary health plan.

Provider — The term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, physician assistants, nurse midwives, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, board certified behavior analysts – doctoral (BCBA – D), board certified behavior analysts (BCBA), ABA therapist credentialed by the National Behavior Analyst Certification Board (BACB) or working under the direct supervision of a BCBA or BCBBA-D, chiropractors, certified nurse practitioners, clinical nurse specialists, Registered Nurse First Assistants (RNFA), physical therapists, occupational therapists, optometrists, and audiologists who are properly licensed and are working within the scope of their practice.

Qualified Medical Expenses (QME) — HSA funds may be used to pay for a variety of medical expense including some that are generally excluded in health insurance plans. The internal Revenue Service established Code Section 213(d) to define the qualified medical expense for which HSA funds can be used. Some examples of QME's include health insurance plan deductibles, copayments and coinsurance amounts; dental services including orthodontics, bridges and crowns; and vision care including LASIK surgery, examination and vision hardware. (Also referred to as eligible medical expenses.)

Reasonable and Customary — NJ DIRECT covers only reasonable and customary allowances, which are determined by the FAIR Health benchmark charge data fee schedule or a similar nationally recognized database. This schedule is based on actual charges by physicians in a specific geographic area for specific services. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you are required to pay. This schedule is updated on a semi-annual basis.

Residential Treatment Facility — A health care facility licensed, by the State of New Jersey for treatment of alcoholism or substance abuse or meeting the same standards, if out-of-state.

Respite Care — Short-term or temporary care provided for the hospice patient in order to provide relief, or respite to the family caregiver.

Retired Group Member — An eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for Retired Group coverage in the SHBP or SEHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving spouse of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll in Retired Group coverage for him/herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing he or she has completed a form constituting written notice of election to enroll in Retired Group coverage.

Roll Over — Horizon *MyWay* HSA members can roll over fund to the next year if unused balances remain at year-end. Any contributions to the HSA in the next year would be added to the amount rolled over.

School Employees' Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.46 and charged with the responsibility of overseeing the School Employee's Health Benefits Program.

School Employees' Health Benefits Program (SEHBP) — The SEHBP was established by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SEHBP. The School Employees' Health Benefits Program Act is found in the N.J.S.A. 52:14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

SEHBP Member — An individual who is either a School Employees' Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

SHBP Member — An individual who is either a State Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Skilled Nursing Facility — A facility which is approved by either the Joint Commission on Accreditation of Health Care Organizations or the Secretary of Health and Human Services and provides skilled nursing care and services to eligible persons. The skilled nursing facility provides a specific type of treatment that falls midway between a hospital that provides care for acute illness and a nursing home that primarily provides custodial, maintenance or supportive care as well as assistance with daily living.

Specialty care — Services provided by a health care professional whose practice is limited to a specific area of medicine (i.e. orthopedics, dermatology, physical therapy, chiropractic manipulation, etc.).

State Biweekly Employee — For health benefits purposes, state biweekly employee means a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time normally requires 35 hours per week.

State Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefits Program Act is found in the N.J.S.A. 52:14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employee — For health benefit purposes, state monthly employee means a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

State Monthly Employer — Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas Edison State College
- William Paterson University
- Ramapo College of NJ
- Rowan University
- The College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State Legislature and Legislative Offices
- New Jersey Building Authority

- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program

Substance Abuse — The abuse of or addiction to drugs or controlled substances, not including alcohol.

Supportive Care — Care for patients that have reached the maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically appropriate are not eligible for coverage under NJ DIRECT.

Surgical Center — Also called a surgicenter. An ambulatory-care facility licensed by a state to provide same-day surgical services.

Surgical Procedure — This includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Surrogate — A woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

Waiting Period — The period of time between enrollment in the health benefits program and the date when you become eligible for benefits.

APPENDIX IV

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents receive coverage under the programs. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children) must submit supporting documentation in addition to the appropriate health benefits application.

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Spouse	A person of the opposite sex to whom you are legally married.	A photocopy of the Marriage Certificate and a photocopy of the front page of the employee/retiree's most recently filed tax return* (<i>Form 1040</i>) that includes the spouse. If filing separately, submit a copy of both spouses' tax returns.
Civil Union Partner	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the front page of the employee/ retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
Domestic Partner	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee/retiree of a SHBP/SEHBP participating local public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners and a photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.

Continued on next page

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Children	<p>A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents.</p> <p>This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.</p>	<p>Natural or Adopted Child – A photocopy of the child's birth certificate** showing the name of the employee/retiree as a parent.</p> <p>Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.</p> <p>Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.</p>
Dependent Children With Disabilities	<p>If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage.</p> <p>See "Dependent Children with Disabilities" on page 5 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.</p>	<p>Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the child.</p> <p>If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.</p> <p>Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.</p>
Continued Coverage for Over Age Children	<p>Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. See "Over Age Children until Age 31" on page 5 for additional information.</p>	<p>Documentation for the appropriate "Child" type (as noted above), and a photocopy of the front page of the child's most recently filed federal tax return* (<i>Form 1040</i>), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.</p>

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: www.state.nj.us/health/vital/index.shtml To obtain copies of other documents listed on this chart, contact the office of the Town Clerk in the city of the birth marriage, etc., or visit these Web sites: www.vitalrec.com or www.studentclearinghouse.org

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

****Or a National Medical Support Notice (NMSN) if you are the non-custodial parent and are legally required to provide coverage for the child as a result of the NMSN.**

APPENDIX V

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

NJ DIRECT meets the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. This includes any prior group plan coverage that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your SHBP or SEHBP group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The SHBP and SEHBP make every effort to safeguard the health information of its members and comply with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health. See page 98 for the [*Notice of Privacy Practices*](#).

APPENDIX VI

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS
TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

EFFECTIVE DATE: APRIL 30, 2013

Protected Health Information

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained and relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP and SEHBP are required by law to abide by the terms of this Notice. The SHBP and SEHBP reserve the right to change the terms of this Notice. If the SHBP or SEHBP make material change to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The SHBP and SEHBP are permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run programs without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The SHBP or SEHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP or SEHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP or SEHBP receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The SHBP or SEHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.

- The SHBP or SEHBP may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The SHBP or SEHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP or SEHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP or SEHBP may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the SHBP or SEHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP or SEHBP may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The SHBP or SEHBP may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the SHBP and SEHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid in the conduct of business (our "Business Associates"). An authorization form may be obtained over the Internet at: www.state.nj.us/treasury/pensions or by sending an e-mail to: hipaaform@treas.state.nj.us A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the SHBP and SEHBP will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The SHBP and SEHBP maintain physical, technical, and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the SHBP or SEHBP have the following rights regarding their PHI.

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the SHBP or SEHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the use of this PHI for claims resolution. The member must make a request in writing to obtain access to

their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the SHBP or SEHBP amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The SHBP or SEHBP may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the SHBP or SEHBP; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the SHBP, SEHBP, or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the SHBP or SEHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP and SEHBP are not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosure: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a flexible spending account or health savings account, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the SHBP or SEHBP communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the SHBP or SEHBP to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Complaints

If you have questions or concerns, please contact the SHBP or SEHBP using the information listed at the end of this Notice.

If members think the SHBP or SEHBP may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the SHBP or SEHBP communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The SHBP and SEHBP support member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP, SEHBP, or with the US Department of Health and Human Services.

Contact Office:

Division of Pensions and Benefits — HIPAA Privacy Officer

Address:

State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
PO Box 295
Trenton, NJ 08625-0295

E-mail: hipaaform@treas.state.nj.us

APPENDIX VII

HEALTH BENEFITS PROGRAM CONTACT INFORMATION

Addresses

NJ DIRECT — Horizon Blue Cross Blue Shield of New Jersey

Mailing Address:

**Horizon BCBSNJ
PO Box 820
Newark, NJ 07101-0820**

Internet Address: www.horizonblue.com/shbp

Division of Pensions and Benefits — Health Benefits Bureau

Mailing Address:

**Health Benefits Bureau
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299**

Internet Address: www.state.nj.us/treasury/pensions/health-benefits.shtml

E-mail Address: pensions.nj@treas.state.nj.us

Please indicate on all correspondence whether you are a SHBP or SEHBP member.

Telephone Numbers

NJ DIRECT

Horizon Blue Cross Blue Shield of New Jersey 1-800-414-7427 (SHBP)

Division of Pensions and Benefits:

Office of Client Services and Automated Information System(609) 292-7524

TDD Phone (Hearing Impaired)(609) 292-7718

State Employee Advisory Service (EAS) 24 hours a day.....1-866-327-9133

New Jersey State Police

Employee Advisory Program (EAP)1-800-FOR-NJSP

Rutgers University Personnel Counseling Service

Employee Advisory Program (EAP)(732) 932-7539

University of Medicine and Dentistry of New Jersey

Employee Advisory Program (EAP)(973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board.....1-800-838-0935

Consumer Assistance for Health Insurance (609) 292-5316 (Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD).....1-800-792-9745

New Jersey Department of Health and Senior Services

Division of Aging and Community Services1-800-792-8820

Insurance Counseling1-800-792-8820

Independent Health Care Appeals Program(609) 633-0660

Centers for Medicare and Medicaid Services

New Jersey Medicare — Part A and Part B 1-800-Medicare

HEALTH BENEFITS PROGRAM PUBLICATIONS

Fact sheets, handbooks, and other publications are available for viewing or printing over the Internet at: www.state.nj.us/treasury/pensions

General Publications

[Summary Program Description](#) booklet — an overview of the SHBP and SEHBP

[Plan Comparison Summary](#) — Out-of-pocket cost comparison charts for State employees, local government employees, local education employees, and all retirees.

[Fact Sheet #11](#), *Enrolling in Health Benefits Coverage When You Retire*

[Fact Sheet #23](#), *Health Benefits Coverage and Medicare Parts A & B for Retirees*

[Fact Sheet #25](#), *Employer Responsibilities under COBRA*

[Fact Sheet #26](#), *Health Benefits Options upon Termination of Employment*

[Fact Sheet #30](#), *Continuation of Health Benefits Insurance under COBRA*

[Fact Sheet #31](#), *Benefits at Termination of Employment*

[Fact Sheet #37](#), *Employee Dental Plans*

[Fact Sheet #47](#), *Retired Health Benefits Coverage under Chapter 330 (PFRS, LEO)*

[Fact Sheet #51](#), *Continuing Coverage for Over Age Children with Disabilities*

[Fact Sheet #60](#), *Voluntary Furlough Program*

[Fact Sheet #66](#), *Health Benefits Coverage for Part-Time Employees*

[Fact Sheet #69](#), *SHBP Coverage for State Intermittent Employees*

[Fact Sheet #71](#), *Benefits under the Domestic Partnership Act*

[Fact Sheet #73](#), *Retiree Dental Expense Plan*

[Fact Sheet #74](#), *Health Benefit Coverage of Children until Age 31 under Chapter 375*

[Fact Sheet #75](#), *Civil Unions*

Member Handbooks

[NJ DIRECT Member Handbook](#)

[Horizon HMO Member Handbook](#)

[Aetna Freedom and Value HD Plans Member Handbook](#)

[Aetna HMO Member Handbook](#)

[Prescription Drug Plans Member Handbook](#)

[Employee Dental Plans Member Handbook](#)

[Retiree Dental Expense Plan Member Handbook](#)

